Bundle Public Board 12 November 2026

Agenda attachments

A - Front cover PUBLIC
B - Membership
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D- Agenda public-12 November 2026 FINAL

88.26 10:00 - Welcome, apologies and declarations of interest

89.26 10:02 - Draft minutes of the public meeting held on 16 September 2026

Minutes- PUBLIC Board meeting- 16 September 2026 DRAFT V1

90.26 10:04 - Matters arising and actions pending from previous meetings

90-26 PUBLIC Matters arising

91.26 10:10 - Patient story

92.26 10:20 - Chair's report

93.26 10:25 - Chief Executive's report

93-26 FINAL CEO Board Report November

94.26 10:35 - Integrated quality and performance report

94-26 (FC) Board Front Cover IQPR M6 6
94-26.1 Trust IQPR_M6 2026_27

95.26 11:00 - Business planning 2027/28

95-26 (FC) QVH Business Planning approach 2027-28
95-26.1 Business planning Initial approach 2027-28 v3

96.26 11:10 - Quality and safety assurance

96-26 Quality & safety assurance report November 2026 FINAL

97.26 Financial, workforce and operational performance assurance

97-26 Finance & performance assurance November 2026 FINAL

98.26 Strategy and culture assurance

98-26 Strategy & culture assurance report November 2026 FINAL

99.26 Audit & risk assurance

99-26 Audit & risk assurance report November 2026 FINAL

100.26 11:25 - Guardian of Safe Working report

100-26 GoSW report November 2026
100-26.1 Appendix 1 Q1 GOSW 26-27
100-26.2 Appendix 2 Q2 GOSW 26-27

101.26 11:30 - Freedom to Speak Up Guardian Report

101-26 (FC) FTSU report
101-26.1 GSL Board Report QVH October 2026

102.26 11:40 - Annual Equalities report 2025/26

102-26 Annual Equalities Report 2025-2026

103.26 11:50 - Bi-annual assessment of addressing health inequalities

103-26 Biannual assessment of addressing Health Inequalities Trust Board

104.26 12:00 - National inpatient survey results

104-26 Annual National Inpatient Survey 2025 Report
104-26.1 Appendix 1 NHS Adult Inpatient Survey 2025 Benchmark Report QVH

105.26 12:05 - Health & Safety annual report 2025/26

105-26 (FC) Health & safety annual report 2025-26

105-26.1 Health & Safety Annual Report 2025-26 V2

106.26 12:10 - Mortality report

106-26 Learning from Deaths Report Quarter 2 2026-27

107.26 12:15 - Annual Flu vaccination planning and performance

107-26 Flu vaccination plan Trust Board
107-26.1 Appendix 1 - Flu campaign comms example

108.26 12:20 - Board Assurance Framework

108-26 Board Assurance Framework (BAF) Board November 2026
108-26.1 BAF summary updated October 2026
BAF001 ACCESS V4
BAF002 CYBER v1
BAF003 DIGITAL V4
BAF004 ESTATES V5
BAF005 FINANCE V3
BAF006 LEADERSHIP CAPACITY V4
BAF007 PEOPLE V4
BAF008 QUALITY V6
BAF009 REGULATION V2
BAF010 SUSTAINABILITY AND STRATEGY V4

109.26 12:25 - Thirlwall Inquiry

109-26 Thirlwall Inquiry 2026

110.26 12:35 - Lord Mann review

110-26 Lord Mann antisemitsim definition adoption

111.26 12:40 - Reservation of Powers and Scheme of Delegation

111-26 Revision of the Reservation of Powers and Scheme of Delegation
111-26.1 RoP SoD revised format 2026-27 - Approved 16 October 2026

112.26 12:45 - Any other business (by application to the Chair)

113.26 Questions from members of the public

Queen Victoria Hospital
NHS Foundation Trust

Business Meeting of the Board of Directors

Thursday 12 November 2026

Session in PUBLIC
10.00-13.00
Education centre (location 40), QVH

MEMBERSHIP
BOARD OF DIRECTORS
November 2026

Members (voting):

Group Chair		Joss Bigmore
Deputy Trust Chair	-	Angela McNab
Senior Independent Director	-	Kalee Talvitie-Brown
Non-Executive Directors	-	Jagjit Dosanjh-Elton
	-	Jo Emmanuel
	-	Nick Page
Group Chief Executive Officer	-	Louise Stead
Managing Director / Chief Medical Officer	-	Tamara Everington
Acting Chief Nursing Officer	-	Liz Blackburn
Interim Chief Finance Officer	-	Ross Dunworth

In full attendance (non-voting):

Associate Non-Executive Directors	-	Aleema Shivji
	-	Vivek Chaudhri
Chief People Officer	-	Helen Edmunds
Acting Chief Strategy Officer	-	Kathy Brasier
Interim Company Secretary	-	Jamie O'Callaghan

Annual declarations by directors 2026/27

Declarations of interests

As established by section 40 of the Trust's Constitution, a director of the Queen Victoria Hospital NHS Foundation Trust has a duty:

- to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the foundation trust.
- not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.
- to declare the nature and extent of any relevant and material interest or a direct or indirect interest in a proposed transaction or arrangement with the
- foundation trust to the other directors.

To facilitate this duty, directors are asked on appointment to the Trust and thereafter at the beginning of each financial year, to complete a form to declare any interests or to confirm that the director has no interests to declare (a 'nil return'). Directors must request to update any declaration if circumstances change materially. By completing and signing the declaration form directors confirm their awareness of any facts or circumstances which conflict or may conflict with the interests of QVH NHS Foundation Trust. All declarations of interest and nil returns are kept on file by the Trust and recorded in the following register of interests which is maintained by the Company Secretary.

Register of declarations of interests

	Relevant and material interests							
	Directorships, including non-executive directorships, held in private companies or public limited companies (with the exception of dormant companies).	Ownership, part ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or QVH.	Significant or controlling share in organisations likely or possibly seeking to do business with the NHS or QVH.	A position of authority in a charity or voluntary organisation in the field of health or social care.	Any connection with a voluntary or other organisation contracting for NHS or QVH services or commissioning NHS or QVH services.	Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with QVH, including but not limited to lenders of banks.	Any "family interest": an interest of a close family member which, if it were the interest of that director, would be a personal or pecuniary interest.	Other
Non-executive and executive members of the board (voting)								
Joss Bigmore Group Chair	Board member, Guildford and Waverly Health and Care Alliance				Surrey & Sussex ICB, Provider Collaborative in Common member			Elected Councillor Guildford Borough Council
Angela McNab Deputy Trust Chair	Non executive director / Vice Chair of Kent and Medway Integrated Care Board Non executive of Dimensions UK Ltd	Shareholder (less than 5%) in Rapid Health	Nil	Nil	Nil	Nil	Nil	Member of Independent Reconfiguration Panel (NDPB) - Advisory
Jagjit Dosanjh-Elton Non-Executive Director	Non-executive director for Social Investment Business Foundation Non-executive director for The Social Investment Business Limited Non-executive director for Public Relations Communications Association Limited Director 100% Shareholder of Ingenious Exec Limited	Nil	Nil	Trustee for TB Alert	Nil	Nil	Sister works as Chief Nurse at Guys and St Thomas Trust. Brother in law works as a Cardiac Consultant at Pembury Hospital Kent	Nil

Jo Emmanuel Non-Executive Director	Nil	Independent consultancy work for different NHS bodies for mental health, none directly linked to QVH	Nil	School governor for West St Leonards primary academy school	Nil	Nil	Nil	Nil
Nick Page Non-Executive Director	Mid & South Essex NHS Foundation Trust: Non-executive director Berkshire & Surrey Pathology Services (contractual JV): Non-executive director Institute of Chartered Accounts in England & Wales: Council Member Chartered Institute for Archaeologists Esher Cricket Club Ltd: Director/Charity Trustee Esher Cricket Club Trading Ltd: Director Carrington Place, Esher, Management Company Ltd: Director Willow Property Management Ltd: Director Willow Investment Holding Ltd: Director	Mid & South Essex NHS Foundation Trust:	Nil	Nil	Nil	Nil	Nil	Nil
Kalee Talvitie-Brown Non-Executive Director	Nil	Nil	Nil	Chair of the Corporate Advisory Group, Evelina Children's Hospital Charity.	Nil	Nil	Nil	Nil
Louise Stead Group Chief Executive	Chair, Surrey & Sussex Cancer Alliance				Surrey & Sussex ICB, member representing			Visiting Professor, University of Surrey

					providers, Chair of Provider Collaborative, Member of Trust Provider Collaborative, member of Provider Collaborative Committee in Common			
Liz Blackburn Acting Chief Nursing Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Kathy Brasier Acting Chief Strategy Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Ross Dunworth Interim Chief Finance Officer	Shareholder and Director: Whireparish Financial Services Ltd	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Helen Edmunds Chief People Officer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Tamara Everington Managing Director	Nil	Nil	Nil	Nil	Nil	Azets (Trust's external auditor) support with annual tax return including evaluation of pension tax liability	Nil	Nil
Aleema Shivji Associate Non-Executive Director	Director of 5 Westborne Villas Freehold Ltd and 5 Chatham Place Freehold Ltd	Nil	Nil	Co-Chair, Peace Direct (charity)	Nil	Nil	Nil	Nil
Vivek Chaudhri Associate Non-Executive Director	Director of Global AI Leaders Network Director of Purposeful AI NED, East London NHS Foundation Trust (ELFT) NED, National Highways	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Fit and proper persons declaration

As established by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the regulations"), QVH has a duty not to appoint a person or allow a person to continue to be a Board member of the trust under given circumstances known as the "fit and proper person test". By completing and signing an annual declaration form, QVH Board members confirm their awareness of any facts or circumstances which prevent them from holding office as a member of QVH NHS Foundation Trust Board.

Register of fit and proper person declarations

	Categories of person prevented from holding office						
	The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.	The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.	The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).	The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.	The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.	The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.	The person has been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.
Non-executive and executive members of the board							
Joss Bigmore Group Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Angela McNab Deputy Trust Chair	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jagjit Donsanjh-Elton Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jo Emmanuel Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nick Page Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kalee Talvitie-Brown Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Louise Stead Group Chief Executive	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tamara Everington Managing Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ross Dunworth Interim Chief Finance Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Liz Blackburn Acting Chief Nursing Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Helen Edmunds Chief People Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kathy Brasier Acting Chief Strategy Officer	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Aleema Shivji Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Vivek Chaudhri Associate Non-Executive Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A

NHS
Queen Victoria Hospital
NHS Foundation Trust

Business meeting of the Board of Directors
12 November 2026
10.00-13.00

Agenda: session held in public			
WELCOME			
88-26	**Welcome, apologies and declarations of interest** *Joss Bigmore, Group Chair*		
STANDING ITEMS		**Purpose**	**Time**
89-26	**Draft minutes of the public meeting held on 16 September 2026** *Joss Bigmore, Group Chair*	*Approval*	*10:02*
90-26	**Matters arising and actions pending from previous meetings** *Joss Bigmore, Group Chair*	*Review*	*10:04*
91-26	**Patient story** *Liz Blackburn, acting Chief nursing officer*	*Discussion*	*10:10*
92-26	**Chair's report** *Joss Bigmore, Group Chair*	*Discussion*	*10:20*
93-26	**Chief Executive's report** *Louise Stead, Group Chief executive officer*	*Assurance*	*10:25*
PERFORMANCE			
94-26	**Integrated quality and performance report** *All executive directors*	*Assurance*	*10:35*
95-26	**Business planning 2027/28** *Ross Dunworth, interim Chief finance officer*	*Information*	*11:00*
COMMITTEE ASSURANCE REPORTS			
96-26	**Quality and safety assurance** *Jo Emmanuel, Non-executive director and committee Chair*	*Assurance*	*11:10*
97-26	**Financial, workforce and operational performance assurance** *Nick Page, Non-Executive Director and committee Chair*	*Assurance*	
98-26	**Strategy and culture assurance** *Angela McNab, deputy Trust Chair and committee Chair*	*Assurance*	
99-26	**Audit & risk assurance** *Jagjit Dosanjh-Elton, Non-executive director and committee Chair*	*Assurance*	
QUALITY, PEOPLE & PATIENT EXPERIENCE			
100-26	**Guardian of Safe Working report** *Tamara Everington, Managing director / Chief medical officer*	*Assurance*	*11:25*

101-26	**Freedom to Speak Up Guardian Report** *Jackie Doherty, Freedom to Speak Up Guardian*	*Assurance*	*11:30*
102-26	**Annual Equalities report 2025/26** *Helen Edmunds, Chief people officer*	*Approval*	*11:40*
103-26	**Bi-annual assessment of addressing health inequalities** *Liz Blackburn, acting Chief nursing officer*	*Assurance*	*11:50*
104-26	**National inpatient survey results** *Liz Blackburn, acting Chief nursing officer*	*Assurance*	*12:00*
105-26	**Health & Safety annual report 2025/26** *Liz Blackburn, acting Chief nursing officer*	*Assurance*	*12:05*
106-26	**Mortality report** *Tamara Everington, Managing director / Chief medical officer*	*Assurance*	*12:10*
107-26	**Annual Flu vaccination planning and performance** *Liz Blackburn, acting Chief nursing officer*	*Assurance*	*12:15*
GOVERNANCE & RISK			
108-26	**Board Assurance Framework** *Jamie O'Callaghan, interim Company secretary* *All executive directors*	*Approval*	*12:20*
109-26	**Thirlwall Inquiry** *Liz Blackburn, acting Chief nursing officer*	*Assurance*	*12:25*
110-26	**Lord Mann review** *Helen Edmunds, Chief people officer*	*Approval*	*12:35*
111-26	**Reservation of Powers and Scheme of Delegation** *Jamie O'Callaghan, interim Company secretary* *Ross Dunworth, interim Chief finance officer*	*Information*	*12:40*
MEETING CLOSURE			
112-26	**Any other business (by application to the Chair)** *Joss Bigmore, Group Chair*	*Discussion*	*12:45*
MEMBERS OF PUBLIC			
113-26	**Questions from members of the public** *We welcome relevant, written questions on any agenda item from our staff, our members or the public. To ensure that we can give a considered and comprehensive response, written questions must be submitted in advance of the meeting (at least three clear working days). Please forward questions to qvh.corporategovernance@nhs.net clearly marked "Questions for the board of directors". Members of the public may not take part in the Board discussion. Where appropriate, the response to written questions will be published with the minutes of the meeting.* *Joss Bigmore, Group Chair*	-	-

	Minutes (DRAFT)	
Meeting:	**Board of Directors (session in public)** **10.00-12.00 16 September 2026** **Education Centre, QVH**	
Present:	Angela McNab (AM)	Interim Trust Chair (voting)
	Jagjit Dosanjh-Elton (JDE)	Non-executive director (voting)
	Jo Emmanuel (JE)	Non-executive director (voting)
	Nick Page (NP)	Non-executive director (voting)
	Abigail Jago (AJ)	Acting Chief executive officer (voting)
	Tamara Everington (TE)	Managing director & Chief medical officer (voting)
	Liz Blackburn (LB)	Acting Chief nursing officer (voting)
	Ross Dunworth (RD)	Interim Chief finance officer (voting)
	Helen Edmunds (HE)	Chief people officer (non-voting)
	Kathy Brasier (KB)	Acting Chief strategy officer (non-voting)
	Vivek Chaudhri (VC)	Associate Non-executive director (non-voting)
In attendance:	Jamie O'Callaghan (JOC)	Interim Company secretary
	Ellie Simpkin (ES)	Governance manager (minutes)
	Katharine Bond (KBo)	Organisational development & learning manager (for staff story)
Apologies:	Kalee Talvitie-Brown (KTB)	Non-executive director (voting)
	Aleema Shivji (AS)	Associate Non-executive director (non-voting)
Members of the public:	Three members of staff, and 14 governors	

58-26 **Welcome, apologies and declarations of interest**

The Chair opened the meeting welcoming members of the Board and those observing the meeting.

The Chair reminded those observing the meeting that they were not invited to participate in discussions and that there would be an opportunity to ask questions at the end of the meeting.

Apologies were received from KTB and AS.

There were no declarations of interest other than those already recorded on the register of interests.

59-26 **Draft minutes of the public meetings held on 09 July 2026 and 23 July 2026**

The Board agreed that the minutes of the public Board meetings held on 09 July 2026 and 23 July 2026 were a true and accurate record and **approved** them on that basis.

60-26 **Matters arising and actions pending from previous meetings**

The Board reviewed the actions from the previous meetings as follows:

Action 7 (65 week waits) – The Board noted that finalisation of the 65 week wait trajectory has been delayed due to Business Intelligence capacity. The action will remain open for a further update.

Action 1 (Bi-annual assessment of addressing health inequalities) – The Board noted the written update provided on the pilot programme of work planned at one of the Trust's spoke sites targeting areas of known deprivation. This action will be closed.

Action 4 (analysis of the Better Value Programmes shortfall) – A summary of the schemes that are contributing to the Better Value Programme shortfall has been included in the Month 03 Cost Improvement update. This action will be closed.

	The Board **noted** the updates.
61-26	**Staff story** The Board welcomed KBo to the meeting, who shared her experience of supporting a bespoke work experience placement for a young person with special educational needs. She reflected on the Trust's role as an Anchor Institution and the importance of ensuring that work experience opportunities are inclusive and accessible to a broader range of young people. KBo explained that, while the Trust's work experience opportunities are openly advertised, applications are predominantly received from academically high-achieving students seeking experience to support applications for medicine or dentistry. A recent request had provided an opportunity to consider how the usual approach could be adapted for a neurodivergent young person who would not have been able to manage a traditional week-long placement. Working with the Organisational Learning and Development Team, a bespoke one-day programme had been developed, incorporating experience across a range of areas including estates, prosthetics and medical devices. Feedback from the placement had been positive, with the young person feeling welcomed and included. Staff involved had also found the experience rewarding and valued the opportunity to demonstrate the breadth of roles undertaken behind the scenes at the Trust. KBo highlighted learning from the placement, including that a one-size-fits-all approach was not appropriate; for future placements, consideration would be given to whether the individual would benefit from shorter sessions, additional breaks, fewer activities and a simplified application process. The importance of the individual having appropriate support throughout a placement was also recognised. The Board welcomed the initiative as supporting the Trust's strategic ambitions and acknowledged the resource implications of providing bespoke placements and the need to balance the number of placements offered with providing richer and more inclusive experiences. It was also recognised that greater consideration should be given to widening access beyond those already well placed to pursue traditional clinical career pathways. The Board thanked KBo for sharing the story and welcomed the learning generated.
62-26	**Chair's report** AM presented the report to the Board, highlighting the following: - The Star Awards had been a spectacular evening, celebrating the dedication and outstanding contributions of QVH staff. - She thanked staff for making time for her service visits, which continue to provide valuable insight relevant to the work of the Board and demonstrate the commitment of staff across the Trust. - Following approval of the Group arrangements, the focus is now on implementing the agreed partnership arrangements. AM thanked Governors for their support with the processes underway to establish the shared leadership arrangements for the Group and congratulated TE on her appointment as the Trust's Managing Director. As the Trust moves into its new leadership arrangements, AM thanked colleagues, Governors and stakeholders for their support during her tenure as Interim Trust Chair. The meeting also marked AJ's final Board meeting as Acting Chief Executive Officer. On behalf of the Board, AM recorded her thanks to AJ for her leadership and considerable contribution during her time in the role. She reflected that AJ stepped into the position at a challenging time and has strengthened the Trust's governance while maintaining a clear focus on operational performance and the quality of care for patients. Her leadership has been instrumental in progressing the partnership arrangements and preparing the Trust for

	its next phase. AM recognised AJ's integrity, visibility and engagement with staff, and the exemplary leadership she had demonstrated throughout her tenure. The Board **noted** the contents of the report.
63-26	**Chief Executive's report** AJ began by acknowledging the publication of the Thirlwall Inquiry report, recognising the distressing nature of its findings and extending her thoughts to all those affected. She reflected on the responsibility of leaders and Boards to create an environment in which concerns can be raised and appropriately challenged and highlighted the importance of maintaining professional curiosity. The Trust will continue to reflect on the learning as the national response develops. AJ presented the report to the Board, highlighting the following: - There is sustained commitment to delivering operational and financial performance. The NHS Oversight Framework (NOF) for Quarter 1 of 2026/27 was published on 10 September 2026 and the Trust has moved from Segment 3 to Segment 1, the highest category within the framework. QVH is ranked 2nd out of 134 acute/specialist trusts nationally and is the highest-ranked trust in the South East. - Planned care continues to be a key challenge and work continues to improve performance to deliver the planned year end position. - Work continues on delivery of the Trust's major projects including the upgrade of the Patient Administration System and East Grinstead Community Diagnostic Centre build, which is now expected to open in November 2026 due to construction delays. - Progress continues against the Trust's strategic priorities, aligned with the ambitions of the NHS 10 Year Health Plan. - She congratulated TE on her appointment as the Trust's Managing Director. As this was AJ's final Board meeting, she thanked AM for her strong strategic leadership and for the support, guidance and constructive challenge. She also thanked colleagues, staff and volunteers for their contribution during a significant period in QVH's history, noting that the Trust has continued to deliver excellent patient care while laying strong foundations for the future. She reflected that it has been an honour to work alongside colleagues. Asked what reflections she would leave with the Board, AJ emphasised the importance of maintaining clarity on organisational priorities as the Trust transitions into the Group model. She reflected that the Trust now has an aligned vision for its future and encouraged the Board to maintain the transparency and connection that enabled this as it works to deliver the QVH Strategy. The Board **noted** the contents of the report.
64-26	**Integrated quality and performance report** KB presented the report to the Board and provided an update on operational performance, highlighting that: - In Month 3, the Trust continued to see pressure across key access standards, driven by sustained growth in referrals and capacity constraints, particularly in Sleep, Skin and Oral and Maxillofacial Surgery (OMFS). The waiting list continues to grow, although the increase in June was lower than in previous months. - Progress is being made to reduce long waits, but the position remains challenged. In Month 3, the number of patients waiting over 78 weeks reduced from 13 to nine, 65-week waits reduced from 42 to 35 and 52-week waits reduced from 254 to 226. In Month 4, 52-week waits reduced further to 223. The forecast is to achieve zero 65-week waits for all patients, apart from those awaiting breast surgery, by September 2026.

- Cancer performance remains under pressure due to an increase in urgent suspected cancer referrals, which are 15.2% above plan. In Month 4, performance remained below trajectory, particularly in Head and Neck, where demand continues to exceed plan. The Trust is working with the Kent Integrated Dermatology Service to better understand referral criteria. The Teledermatology service continues to be developed and opportunities to use AI technology in this area are being explored with strategic partners.
- Month 3 diagnostic performance (DM01) was 86.7% against a target of 91%, largely driven by challenges in sleep diagnostics.
- In Month 4, theatre utilisation increased to 81.7%, supporting elective recovery.
- Faster Diagnosis Standard performance in August was 62.7% against a target of 80%.
- Work continues to maximise capacity and manage the increase in the waiting list. The Trust is working with NHS England on the actions being taken to address the challenges, supported by bi-weekly performance meetings.

The Board discussed the waiting list challenges and the response from commissioners to the increase in cross-border activity. KB advised that further clarity is expected over the coming weeks as discussions continue with System partners. The opening of sleep services at University Hospitals Sussex NHS Foundation Trust is expected to have a positive impact. JDE asked about the balance, from a financial perspective, between returning activity and increasing capacity at QVH to reduce waiting lists. It was noted that the appropriate approach depends on the individual service. Sleep activity is above planned levels and increasing capacity will take time, presenting an in-year challenge. The Board also noted the importance of maintaining focus on outpatient capacity and productivity.

JDE sought assurance on the grip and control of patient waiting lists. KB explained that a review of waiting list management has been undertaken and actions arising from the review are being implemented. There is weekly Executive oversight of the Patient Tracking List and she is confident that appropriate grip and control arrangements are in place. AJ added that specific services are having a disproportionate impact on overall performance, with Sleep affecting both waiting list and diagnostic performance and Breast contributing to 65-week waits. Confidence in the performance of other services remains strong.

LB provided an update on quality and patient experience. She highlighted that the Trust's Friends and Family Test performance continues to be consistently above the national benchmark. A Falls Oversight Group is being established to provide further insight. There has been a reduction in care hours per patient day, reflecting the bed reconfiguration and associated changes to staff deployment, while safer staffing compliance remains strong at 99%.

JE noted that ethnicity recording remains below expected levels and asked whether the reasons for limited improvement, particularly within Plastics, have been identified. LB explained that the team is working with General Managers to ensure staff understand why the information is being requested and that this is also explained to patients. Outpatients will be a particular area of focus over the coming months.

TE provided an update on research, innovation and digital. She highlighted the value of applying Continuous Improvement methodology in finding solutions to the challenges facing the Trust. The Trust's digital transformation programme is ambitious and transitioning the organisation from analogue to digital, ensuring it has access to the data required to inform decision-making, is key. There remain a number of critical dependencies ahead of the planned PAS go-live, currently scheduled for the final weekend in November 2026. The Executive Team is committed to its delivery, but there are technical considerations still to be resolved and the final decision to proceed will be based on assurance that it is clinically safe to do so. The system will support increased efficiency and reduce administrative tasks, such

	as e-prescribing for paediatrics. There is a delay to delivery of the East Grinstead Community Diagnostic Centre, which will now formally open in 2027. The building will support new ways of delivering diagnostic services for the local community. Agreement has now been reached with the supplier for the Sussex Pathology Network, placing the programme in a strong position for delivery in the next financial year. HE provided an update on workforce, reporting that workforce metrics are broadly stable. There has been an increase in Bank usage in Month 4, primarily due to additional theatre sessions and activity in sleep services. There was improvement in appraisal and Mandatory and Statutory Training compliance in Month 3, with a decline in training compliance in Month 4 primarily due to the introduction of additional statutory infection prevention and control e-learning. The trajectory to return to target levels remains on track. Sickness absence continues to be above target. Long-term sickness has improved; however, there has been an increase in short-term sickness within some of the same areas. Managers are being supported to manage this in line with policy. The Board noted the changing profile of sickness absence but that this continues to affect the areas discussed at the July Board meeting. Annual leave usage is being monitored and is tracking well. Organisational development activity continues, including delivery of the Behaviour Framework workshops, Managers Essentials programme and resilience and change support. Oliver McGowan Tier 2 face-to-face training is progressing, with 34% of staff required to undertake the training having now completed the course. RD provided an update on financial performance. The Trust delivered its planned Month 3 financial position, with a £0.34m year-to-date deficit in line with the plan to achieve breakeven at year end. The Better Value Programme (BVP) is currently forecasting a shortfall of approximately £1.5m. RD noted that the Trust's position is not dissimilar to other organisations when considered as a percentage of the overall programme. Further grip and control is being applied to address underperformance in clinical activity, including Plastics and Maxillofacial day cases, alongside continued focus on bringing the pay bill into line with plan and ensuring the appropriate use of temporary staffing. The Board discussed the implications of a year-end deficit, including the potential impact on the Trust's NHS Oversight Framework position, increased oversight from NHS England and constraints on the Trust's ability to manage and invest its capital resources. RD explained that achieving breakeven remains a key organisational risk, however, actions are being put in place to mitigate this. A route map to achieve the breakeven plan is being developed and opportunities to secure additional income are being explored. At this stage, RD remains relatively confident that the Trust will be able to achieve its planned year-end position. In response to a question on the underlying deficit and the reasons for the BVP shortfall, RD explained that a reasonable proportion of the programme has been delivered, however, it is a stretch target which carries risk. After excluding non-recurrent benefits, the underlying position presents a potential risk of approximately £1.5m to £2m going into the next financial year. The pay bill overspend needs to reduce and the risk going into the next financial year considered and managed. KB provided an update on partnership and collaboration. Delivery of the engagement plan continues, alongside consideration of communications across the Group. With regard to Provider Collaboratives, QVH has identified ten priority specialties for enhanced triage, advice and guidance processes as part of the Surrey and Sussex Single Point of Access collaboration programme, which are due to be delivered in October 2026. In response to a question on the timescale for developing the benefits realisation approach for the strategic partnership, KB explained that work has started on identifying three to four initial areas of focus. Assurance on delivery and benefits realisation will be provided to the Board through the relevant Board sub-committees.

	The Board **noted** the contents of the report.
65-26	**Quality and safety committee assurance** JE presented the report to the Board, highlighting the committee's continued focus on the impact of waiting times, workforce and estates challenges through a quality lens. Progress is being made on the delivery of the Quality Priorities for 2026/27 and to reduce the historic incident backlog. The Board **noted** the contents of the report.
66-26	**Financial, workforce and operational performance assurance.** NP presented the report to the Board. Key matters discussed by the committee include the continued demand on services, delivery of the Trust's Better Value Programme and progress with the Patient Administration System (PAS) upgrade. VC queried the availability of funding for the digital team following implementation of the PAS upgrade. TE advised that the Trust has secured additional support from the NHS England 'tiger team' for the PAS implementation, however, a longer-term funding risk remains in relation to the Trust's digital transformation programme. The Board **noted** the contents of the report.
67-26	**Strategy and culture assurance** AM presented the report to the Board as read, noting that the committee will maintain overall oversight of the Strategic Partnership Benefits Realisation Framework as it is developed. The implementation of specific benefits arising from individual partnerships will be reported to the relevant Board sub-committees. The Board **noted** the contents of the report.
68-26	**Research & Innovation Strategy update** TE presented the report to the Board, highlighting key areas of progress including the plans to create the Research, Innovation and Education Centre which will deliver a new, innovative environment. Work is underway to strengthen commercial opportunities, supported by the appointment of the Commercial Lead. There is potential to realise further opportunities through the Group partnership. The Board commended the strategic approach being taken, underpinned by the embedding of Continuous Improvement, and welcomed the breadth of ambition both within the Trust and across the Group. It acknowledged the challenge of maintaining focus on longer-term strategic objectives alongside immediate operational priorities and welcomed the progress being made. The Board **noted** the contents of the report.
69-26	**Workforce Race Equality Standard and Workforce Disability Equality Standard Annual Reports 2025/26** HE introduced the reports to the Board. Workforce diversity continues to improve, with BME and disabled staff representation increasing compared with 2024/25. Areas of improvement include a reported reduction in bullying and harassment experienced by both BME and disabled staff, and a reduction in disabled staff reporting feeling pressure to attend work despite being unwell. Areas of focus for 2025/26 include improving recruitment and career progression outcomes and strengthening succession planning and talent management. There continues to be engagement with the Trust's Equality, Diversity and Inclusion

	Champions and listening to staff with lived experience to inform future actions. Consideration is being given to how staff networks will be developed across the Group. In response to a question regarding the finding that white applicants remain almost three times more likely to be appointed from shortlisting than BME applicants, HE explained that the data includes applicants who did not have the right to work in the UK and whom the Trust was unable to sponsor due to immigration salary threshold requirements. Consideration is being given to how these applicants could be identified at an earlier stage of the recruitment process. The Board **noted** the contents of the reports and actions being undertaken to address key priorities.
70-26	**Gender Pay Gap Report as at 31 March 2026** HE presented the report to the Board. While remaining higher than the Trust would like, the Trust's gender pay gap has improved. The pay gap continued to be driven by workforce composition rather than unequal employment practices. A deep dive into the pay gap found no evidence of bias in recruitment, development or progression processes. The Board **noted** the content of the report and actions being undertaken.
71-26	**Ethnicity Pay Gap Report as at 31 March 2026** HE presented the report to the Board explaining that the Ethnicity Pay Gap continues to improve in favour of BME colleagues, driven by the Trust having a higher proportion of BME staff employed within senior clinical, scientific and medical roles. In response to a question on the Trust's readiness for a Disability pay gap report, which is expected to become a statutory requirement, HE explained that the quality of data will depend on staff declarations. The importance of developing a culture which allows staff to feel comfortable to do this is recognised. The Board **noted** the content of the report and actions being undertaken.
72-26	**Culture Diagnostic Review** HE presented the report to the Board, explaining that it provides an updated analysis of QVH's organisational culture mapped against the Trust's values and behaviour framework. The review builds on the 2024 culture diagnostic, using the same analytical framework to enable comparison over time. The key insights from the report include that QVH continues to have a strong cultural foundation, with staff committed to delivering high-quality patient care and strong team relationships. Areas for further focus included enabling staff to influence change and act on ideas, strengthening organisational leadership visibility and responsiveness, and addressing ongoing wellbeing pressures associated with workload and capacity. HE noted that the findings will help to inform cultural alignment with the strategic partners as the Trust moves towards new ways of working. Work is underway with Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey NHS Foundation Trust to develop a culture dashboard and the findings will inform actions to improve staff experience and, in turn, patient experience and care. The Board discussed the relationship between organisational culture and the period of change for the Trust. It was acknowledged that the requirement to deliver the Better Value schemes, for example, could present a cultural risk, reinforcing the need for actions to be appropriately targeted and prioritised. AJ emphasised the importance of building on the positive aspects of QVH's culture to support staff through strategic change. In response to a question about learning from teams with a positive culture, HE advised that analysis of the

	Staff Survey and wider cultural data is being used to identify and amplify areas of good practice, enabling teams to learn from one another. The Board also noted the importance of reflecting on emerging learning from the Thirlwall Inquiry, particularly in relation to organisational culture, relationships and openness, and considering this through the lens of the Trust's ongoing cultural development. The Board **noted** the contents of the report and the areas for consideration, which will inform ongoing work to empower staff, further develop QVH as a learning organisation and improve staff and patient experience.
73-26	**National Cancer Patient Experience Survey** The Board received the Trust's results of the National Cancer Patient Experience Survey (NCPES) 2025. LB presented the report to the Board, highlighting the above national average response rate and the Trust's overall care rating of 9.0/10. Six areas were rated significantly above the expected range, including communication, involvement in care, emotional support, and dignity and respect. 95% of patients found it easy to contact their main cancer contact person which is vital for patients during what is a very difficult time. In response to a question about how the Trust could influence improvements to radiotherapy information and treatment outcomes which were rated below the expected range, LB acknowledged that radiotherapy forms a key part of the patient pathway; the Trust will be reviewing this with partner organisations responsible for delivering radiotherapy services. The Board congratulated staff on the positive results. The Board **noted** the contents of the report.
74-26	**Premises Assurance Model** HE presented the report to the Board, noting that fundamental changes to the NHS England approach to the Premises Assurance Model (PAM) mean that comparison with the previous year's submission is not possible. The revised assessment requires a response of yes, no or not applicable, with no option for partial compliance. The Trust has provided a positive response in 65% of areas. An action plan is being developed to address the areas requiring improvement. JDE commented that estates risks continue to be high scoring risks for the Trust. While issues such as the age of the estate and the availability of funding are outside the Trust's control, there are elements which can be controlled, such as the records management and maintenance of registers. The importance of demonstrating that all reasonable action is being taken to mitigate the risks within the Trust's control was noted. The Board **noted** the contents of the report and **approved** the submission of the PAM for QVH to NHS England.
75-26	**Winter Plan 2026/27** KB presented the report to the Board, explaining that the Winter Plan sets out how QVH will maintain safe, effective and sustainable services throughout winter 2026/27 while supporting wider system resilience. KB highlighted that QVH is able to support winter resilience through maintaining elective productivity, reducing avoidable Emergency Department attendances through the Minor Injuries Unit, expanding diagnostic capacity and continued collaboration on mutual aid. The Board **approved** the Winter Plan 2026/27 for submission to the Integrated Care Board.

76-26	**Provider Capability Assessment 2026** AJ presented the NHS England Provider Capability Self-Assessment 2026 to the Board to approve submission to NHS England. The assessment has been reviewed through the Trust's executive governance arrangements and by Non-Executive Directors. The Audit & Risk Committee has also reviewed the assessment and recommends it to the Board for approval. The Board **approved** the NHS England Provider Capability Self-Assessment 2026 and **authorised** submission of the approved assessment to NHS England.
77-26	**Board Assurance Framework** JOC presented the report to the Board, noting that the Board Assurance Framework (BAF) reporting continues to be developed. The BAF is now being reviewed by the Executive Leadership Team through dedicated review sessions, strengthening oversight of the interdependencies between risks. The Quality & Safety Committee has considered whether the current score for the Quality BAF remained appropriate, in light of improvements to controls, actions and assurance mechanisms, and this will be considered by the Executive Leadership Team at its next review session. The Board discussed the potential inclusion of risk score trends and trajectories within future reporting, together with greater visibility of the rationale and discussion underpinning risk scores. It was noted that a Board risk appetite session will be arranged in the coming months, providing an opportunity for a more comprehensive discussion on the BAF. The Board **confirmed** that the BAF appropriately reflects the principal strategic risks facing the Trust.
78-26	**Committee Terms of Reference** JOC introduced the report to the Board, explaining that temporary changes to the committee Terms of Reference are required following recent changes to Board composition with a reduction in the number of Non-Executive Directors serving on the Board from five to four. The Board **approved** the changes to the Finance & Performance and Strategy & Culture Committee Terms of Reference.
79-26	**Any other business (by application to the Chair)** There was none and the meeting was closed.
80-26	**Questions** There were no questions received from members of the public. The Chair invited the lead governor to ask questions regarding any of the items discussed during the meeting on behalf of the governors. The lead governor asked the following question. *Question* How is the shared interim Chief Finance Officer role working? What are the advantages or disadvantages of the arrangement? *Response* RD commented that the arrangements are working well. Opportunities to work collaboratively on procurement, strengthen the capacity of financial management teams and share knowledge are being explored.

Matters arising and actions pending from previous meetings of the Board of Directors -PUBLIC								
ITEM	**MEETING Month**	**REF.**	**TOPIC**	**AGREED ACTION**	**OWNER**	**DUE**	**UPDATE**	**STATUS**
7	March 2026	148-26	65 week waits	Share trajectory to reach zero 65 week waits with the Finance and performance committee	~~**KT**~~ **KB**	~~**June 2026***~~ **September 2026**	May 2026: Forecast for Q1 shared and discussed at the May 2026 Finance and performance committee. The trajectory for the remainder of 2026/27 will be shared with the committee for discussion at the June 2026 meeting. July 2026: The trajectory for the remainder of 2026/27 is in progress and will be shared at the next Finance and Performance Committee. September 2026: Trajectory finalisation delayed due to Business Intelligence capacity. Discussions are underway across the partnership for potential support. November 2026: Trajectory shared and discussed at Finance and performance committee and therefore Board action can be closed.	**Closed**

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026		**Agenda reference:**	**93-26**	
Report title:	Group Chief Executive Officer (CEO) report				
Sponsor:	Louise Stead, Group Chief Executive Officer				
Author:	Tamara Everington, Managing Director Allison Hunter, Strategy Support Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To update on key developments, achievements and risks since the last Board meeting.				
Summary of key issues	This report provides an update on key external developments, including the Government's plans for a new National Care Service and the Surrey and Sussex commissioning intentions for 2027/28, which reinforce QVH's role in supporting integrated, accessible and sustainable healthcare services. It also contains internal items of importance and interest, including the expansion of the strategic partnership with Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey NHS Foundation Trust, an update on the Trust's improved National Oversight Framework (NOF) position, progress against strategic objectives and major programmes, developments in workforce initiatives including the staff flu vaccination programme, and recognition of the achievements of QVH staff and services.				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	***To innovate and improve***	***To be an excellent employer***	***To deliver sustainable services***	***To collaborate with others***
Implications					
Board assurance framework:	All				
Organisational risk register:	All				
Regulation:	None				
Legal:	None				
Resources:	Resource impact as identified within the report.				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Chief Executive Officer (CEO)

1. PURPOSE OF THE REPORT

1.1 To highlight to the Board key issues of relevance

2. MAIN REPORT – EXTERNAL

2.1 Government Vision for New National Care Service

The Prime Minister (PM) has set out plans for a new National Care Service, highlighting the important role social care plays in supporting timely discharge, improving patient flow and reducing pressure on hospitals. For QVH, this reinforces the importance of working closely with system partners to minimise delays in patient discharge and improve patient experience.

2.2 Surrey and Sussex Commissioning Intentions 2027/28

The latest Surrey and Sussex commissioning intentions reinforce QVH's role in delivering neighbourhood health, improving access, reducing inequalities, increasing productivity and supporting pathway transformation through collaborative working across providers and systems.

The focus is on delivering affordable, evidence-based service change with clear outcomes, benefits, financial impact, workforce implications and delivery plans. Providers are expected to support pathway-based commissioning arrangements, demonstrate value for money, and maintain robust governance, performance oversight and risk management to support delivery of system priorities. QVH has responded formally to the proposal and awaits a further response.

2.3 Thirlwall Inquiry Report

The Thirlwall Inquiry Report, published on 15 September 2026, identified significant failures in the escalation and investigation of patient safety concerns, alongside weaknesses in governance, safeguarding, and organisational culture and oversight arrangements. The report makes a number of national recommendations to strengthen safeguarding, leadership accountability, speaking-up arrangements and processes for responding to suspected deliberate harm. A full paper is tabled later on the agenda.

3. MAIN REPORT – INTERNAL

3.1 Strategic Partnership

Following the expansion of our group partnership to include QVH alongside Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH) and Royal Surrey NHS Foundation Trust (RSFT), I am delighted to extend my role as Group Chief Executive Officer to QVH and welcome Joss Bigmore, as QVH Chair, in addition to his existing responsibilities across the Group. Together with Tamara Everington, QVH Managing Director, Angela McNab, QVH Deputy Chair and Non-Executive Director, and colleagues across the Board and wider leadership team, we will focus on realising the benefits of our partnership while building on QVH's expertise, identity and strengths.

3.2 National Oversight Framework (NOF)

NHS England published the latest results from the updated NHS Oversight Framework (NOF) for the first quarter of the new financial year. I am pleased to share that QVH has been placed in Segment 1, position 2 out of 134 acute/specialist trusts nationally and are the highest-ranked acute/specialist trust in the South East.

We are also rated in the top category for five of the six areas assessed: patient safety, experience of care, effectiveness of care, people, and finance, productivity and innovation. The remaining area, patient access to services, reflects the challenges we continue to address in reducing waiting times and improving timely access to care.

It is worth noting that NHS England has introduced changes to both the metrics and methodology for 2026/27. Organisations are now assessed against clear and consistent expectations, rather than being placed into quartiles solely according to their position relative to peers. This is intended to provide clearer improvement goals and more stable segmentation. Consequently, the latest results should be interpreted in the context of the updated approach.

We will continue to review our current NOF metrics; however, based on the current performance position, there remains a risk of deterioration in Q2 and Q3.

3.3 *QVH Strategy 2025-2030*: 2026/27 Year 2 Delivery

Good progress has been made across all five Key Strategic Objectives (KSOs) during the first six months of 2026/27. Key achievements include progressing the strategic partnership, completion of Phase 1 Local Anaesthetic Unit programme, approval of the new MRI scanner, advancement of the Research, Innovation and Education Centre, and strong NHS National survey results. Focus will remain on improving performance against national access standards, delivering the Better Value programme and implementing major programmes including CDC and PAS. Work is in progress to develop 2027/28 KSOs alongside broader planning intentions. This will support alignment of priorities and objectives across the group.

3.4 Major Projects

The facility was formally handed over to the Trust on 20 October two days later than had been planned to allow for completion of critical building components. Following final building control approval, it is planned to open the Community Diagnostic Centre on 9 November 2026. A detailed programme of focussed work is underway to prepare for opening including optimisation, installation of equipment and clinical / operational preparedness to enable patient assessment in the centre to start on the afternoon of 9 November.

Archie PAS scheduled for go-live at the end of November 2026 has been deferred until spring 2027, in agreement with NHS England. As a first of type product, issues identified through testing and constraints across several workstreams have necessitated a revised implementation timeline. The additional time will support robust testing, resolution of outstanding issues and staff training. This will ensure a safe go-live and minimising risks to patient care and service delivery.

3.5 Our People

<u>Staff Flu Vaccination Programme</u>

The Staff Flu vaccination programme commenced on the 1 October 2026, with clinics held in the Occupational Health service and our roaming vaccinators. All staff have been offered the opportunity to receive a flu vaccination. At the time of writing on Thursday 29 October 2026,

404 staff have been vaccinated (either here or elsewhere), taking our overall compliance to 34%, including 29% of frontline staff, and we remain on track with our plan. Efforts continue to maximise the uptake across all staff groups to support organisational resilience during the winter months

Workforce

An enhanced focus on appraisal completion is being led by the executive leadership team and senior managers to support objective setting, development and wellbeing discussions. NHS Staff survey follow-up sessions continue across teams to review priorities and progress improvement plans, while staff are encouraged to participate in the 2026 survey to ensure their views are heard.

In keeping with Trust policy and national direction, a focused programme of work is in progress to ensure consultant job plans are completed, accurate and up to date, supporting workforce planning, service delivery and productivity.

3.6 Supporting Patients and Raising Awareness

Organ Donation Week (21-27 September) was marked by illuminating the Trust clock tower pink to raise awareness of corneal donation and encourage people to share their donation wishes. In October, the Trust also hosted a Living with Facial Palsy event with Facial Palsy UK and Queen Victoria Hospital Charity, welcoming around 40 people with facial palsy, their families and carers for specialist advice, support and peer connection, reflecting QVH's national leadership in both corneal transplantation and facial palsy care

3.7 Awards and Clinical Development

Values in Practice (VIP) Award Winners

August's winner was Sally Clements, Clinical Support Worker in the Burns Unit, recognised for demonstrating the Trust value of being caring and inclusive through her compassionate support for patients and colleagues. September's winners were John Hobden and Kevin Tyrell-Dann from the Gardening Team, recognised for creating a positive and inclusive work experience placement that helped a neurodivergent young person build confidence and achieve their potential.

QVH Surgeon elected to lead European Association

We were delighted to see Mr Ash Gulati, Consultant Oral and Maxillofacial Surgeon – Head and Neck, elected Junior President Elect of the European Association for Cranio-Maxillo-Facial Surgery. This prestigious appointment reflects both his personal achievement and the strength of QVH's specialist oral and maxillofacial surgery services.

Archie EPR wins a Health Tech Award

The Trust, alongside Altera Digital Health, received a national Health Tech Award for the successful implementation of Archie EPR. The Major Project Go Live award recognised the largest digital transformation programme in QVH's history, delivered without cancelling clinics or theatre activity, and acknowledged the contribution of colleagues across the Trust, particularly the Digital Champions, in supporting a smooth transition.

Investing in the latest technology for Cataract surgery

QVH has invested in the UNITY cataract surgery platform for our specialist Corneoplastic service, making QVH one of a small number of NHS organisations to offer this technology. The system supports greater precision and control during cataract surgery and will benefit patients undergoing both routine and complex procedures, reflecting our ongoing commitment to innovation and clinical excellence in ophthalmic care.

4. CONCLUSION

The above items note the key external and internal issues of interest

Recommendation

The Board is asked to:

- **NOTE** the contents of the report

Report cover-page			
References			
Meeting title:	Board of Directors		
Meeting date:	12/11/2026	**Agenda reference:**	**94-26**
Report title:	Integrated Quality and Performance Report Month 6		
Sponsor:	Kathy Brasier, Acting Chief Strategy Officer		
Author:	Kathy Brasier, Acting Chief Strategy Officer		
Appendices:	Appendix – Integrated Quality and Performance Report (IQ&PR) M6 slide pack		
Executive summary			
Purpose of report:	To discuss the Month 6 Integrated Quality and Performance Report 2026/27		
Summary of key issues	**KSO 1 – To deliver outstanding care:** Performance remains challenged across access standards, with continued sustained referral growth within Sleep Services remaining the principal risk to delivery of Referral to Treatment (RTT) and diagnostic recovery, driving waiting list growth and underperformance against trajectory. Significant RTT pressures continue within Sleep, Oral & Maxillofacial Surgery (OMFS) and Plastics, while cancer performance remains impacted by demand and capacity challenges within Skin, Breast and Head & Neck pathways. Emerging pressures within Ultrasound services and continued growth in the 40-51 week waiting cohort present further risks to delivery of year-end recovery trajectories. Successful implementation of specialty recovery plans and capacity interventions will be critical to improving performance during H2 and supporting delivery of Key Strategic Objective (KSO) 1 (Outstanding Care). Revision of year end trajectories has been completed and presented to the Finance and Performance Committee in early November to support recovery. **KSO 2 – To innovate and improve:** Research, Innovation and Education (RI&E) Centre programme remains on track, with ongoing stakeholder engagement shaping the future facility. Research and academic partnerships continue to strengthen, including collaboration with the University of Sussex and preparation for future National Institute for Healthy and Care Research (NIHR) funding opportunities. The QVH Way for Continuous Improvement and organisational learning continues to develop, supported by huddles, shared learning and national improvement networks. Medical education priorities are progressing, including resident doctor support, General Medical Council (GMC) action plans and successful recruitment to key roles. **KSO 3 – To be an excellent employer:** There has been a decrease in bank use in M6, but a small increase in agency use. This increase is mainly in day surgery, recovery and theatres due to additional activity and covering sickness absence. Mandatory and Statutory training rates have improved to 91.5%, with a continued focus on information governance and conflict resolution. Sickness absence levels remain stable, but still marginally above target, with the highest areas being Theatres, radiology and Canadian Wing, with an improving trajectory. Team interventions are continuing to support improvements in team dynamics, alongside coaching, mentoring, managers' essential programme and change / resilience workshops. **KSO 4 – To deliver sustainable services:** The Trust delivered its planned financial position at Month 6 and achieved its efficiency target; activity income has continued to deliver with underperformance being offset by additional referrals. Delivery of the full-year Better Value Programme continues to require close oversight with the shortfall being covered by the Trust recovery plan, this will ensure delivery of the Trust financial plan. CDC, Digital Transformation and Estates programmes continue to progress. **KSO 5 – To collaborate with others:** Following QVH's formal inclusion within the Group partnership with ASPH and RSFT, the leadership structure is now fully established, providing a strong foundation for the next phase of collaborative working. Work is also underway to shape our focus for the next three to six months with a number of agreed priorities.		

	The Provider-Led Single Point of Access (SPoA) programme has been delivered as planned, with all 10 specialties successfully transitioned to the eRS-based SPoA model.				
Recommendation:	Trust Board is requested to review the Month 6 IQ&PR position				
Action required	Approval	Information	**Discussion**	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	***To innovate and improve***	***To be an excellent employer***	***To deliver sustainable services***	***To collaborate with others***
Implications					
Board assurance framework:	BAF 4- long term sustainability (this supports the delivery of the Trust's strategy) BAF5- compliance (addresses the well led review recommendations, supports the implementation of continuous improvement methodology)				
Corporate risk register:	CRR – organisational risk register in development				
Regulation:	ICS, NHS England, CQC				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	N/A				
	Date:		Decision:		
Next steps:	Finance and Performance Committee / Trust Board				

Queen Victoria Hospital
NHS Foundation Trust



Queen Victoria Hospital

Integrated Quality and Performance Report

Month 6: September 2026

BALANCED SCORECARD

Queen Victoria Hospital
NHS Foundation Trust

Priority Metrics	M12 target	Latest month	Planned trajectory in month	Actual performance in month	Previous Month	Summary	Confidence in delivery (RAG)
Breakeven YTD	£0.16m (surplus)	Sep-26	£0.13m (surplus)	£0.13m (surplus)	£0.26m (deficit)	The Trust's Income and Expenditure position was in line with the plan in month	
RTT 18 Week Wait Performance	69.4%	Sept-26	63.3%	60.3%	60.8%	Not achieving target in month and Q1	
Cancer 62 days	80%	Aug-26	73.6%	75.00%	75.92%	Not achieving target	
% Overall FFT Recommendation Rate	90%	Sep-26	90%	95.07%	94.91%	Achieving target	
Trust sickness rate – Rolling 12 months	3.8%	Sep-26	3.9%	4.33%	4.39%	Not achieving target in month	

Major Project	This Month	Overall Status	Last Month	Summary
To deliver the Community Diagnostic Centre (CDC) programme at East Grinstead		On track		Building takeover completed in October 26, ongoing works to enable 9th November centre opening.
Strategic Partnership Transition and Implementation		On track		Leadership in place, governance changes progressing. Work in progress to shape focus for next 3-6 months.
To deliver the **Digital Transformation** Programme		On track		Delay in PAS programme to Spring 2027. Financial risk to programme sustainability from December 26.
To deliver the **Key Estates Infrastructure Projects (MRI scanner, Research, Innovation & Education (RI&E) Hub)**		On track		Task and finish groups established for both MRI and RI&E Centre. MRI scanner preferred provider chosen. Designs commissioned for the relevant spaces.

CEO SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Alert

- Delivery of KSO 1 (Outstanding Care) continues be in a challenged position.
- Referral to Treatment (RTT) performance continues to be significantly below trajectory at 60.3% against a planned 63.3%, with the waiting list increasing to 22,365 pathways and continued growth in patients waiting over 52 weeks. The greatest pressures remain within Sleep Services, Oral & Maxillofacial Surgery (OMFS) and Plastics, driven by sustained referral growth and capacity constraints.
- Diagnostic DM01 performance remains constrained at 85% against a 91% trajectory, this is largely due to ongoing pressures within Sleep Diagnostics and deteriorating Ultrasound performance related to workforce vacancies.
- Cancer performance remains below plan, particularly within Skin, Breast and Head & Neck pathways, where demand, diagnostic delays, outpatient constraints and treatment capacity continue to affect delivery of the 62-day standard.
- The growth in the 40–51-week cohort and long waiters represents a continuing risk to achieving RTT recovery trajectories during the second half of the year.
- Replacement of the Patient Administration System has had to be deferred from end November 2026 into 2027/28 to allow for resolution of issues identified in testing and planning.

Assure

- Recovery continues to remain a key organisational priority supported through strengthened governance, weekly performance oversight, specialty recovery plans and targeted escalation processes.
- Recovery plans and trajectories have been developed at both Trust and specialty level, aligned to delivering the required year-end position.
- Despite access challenges, activity levels remain strong with 352 more clock stops than planned in Month 6 and theatre utilisation increasing to 82.4%, delivering 1,157 procedures, the second-highest monthly activity this year.
- Cancer pathways have enhanced oversight arrangements in place, with focused capacity interventions and pathway management improvements supporting recovery. The Faster Diagnosis Standard (FDS) is showing signs of improvement and is expected to return to trajectory.
- Good progress continues against the 2026/27 Key Strategic Objectives (KSOs). Planning for the 2027/28 objectives is underway with development of corresponding Directorate objectives to ensure clear alignment across the group.
- The East Grinstead Community Diagnostic Centre remains a significant strategic enabler for delivery of both KSO 1 (Outstanding Care) and KSO 4 (Sustainable Services). Following notification of a revised construction programme, building handover took place in October 2026, ongoing works are underway for operational opening on 9th November 2026.
- Digital transformation programmes are progressing with delivery of better value opportunity, optimisation of the Electronic Patient Record (EPR) and agreement on a revised delivery timeline for the Sussex Pathology Network programme.
- Financial performance remains stable, with the Trust reporting a £0.1m year-to-date surplus in line with plan and a forecast for a breakeven position subject to successful delivery of recovery plan actions.
- The Provider-Led Single Point of Access (SPoA) project has been successfully completed, with all 10 specialties now operating through eRS. Focus has shifted to supporting the development of a Sussex-wide elective SPoA model to improve patient access, choice and waiting times across the system.

Advise

- Executive focus remains on recovering RTT, diagnostics and cancer performance, with particular attention on Sleep Services, OMFS and Skin.
- Delivery of specialty recovery plans, additional capacity initiatives, pathway redesign and demand management interventions will be critical to improving performance trajectories during H2.
- Continued monitoring of referral growth, particularly within Sleep Services, remains essential as this continues to be the principal risk to achieving operational recovery targets.

Tamara Everington
Managing Director

Queen Victoria Hospital
NHS Foundation Trust

KSO1

To deliver outstanding care

Ambition

Quality at the centre of what we are and do for patients, families and communities

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

2026/27 Annual Objectives

1. Delivery of Access Targets (Referral to Treatment (RTT), Cancer, Urgent and Emergency Care (UEC), Diagnostics (DMO1) delivery, including the National Cancer Plan
2. Strategic Service Reviews for burns, prosthetics and breast in liaison with commissioners
3. Quality priorities: Health Inequality Did Not Attend (DNA) & Access, Patient Schools, Outcomes & Effectiveness measures

2026/27 Annual goals

1. RTT – 18 week performance to meet 69% by March 2027. Cancer – FDS performance to meet 80% throughout 2026/27. By March 2027, 31 day performance to meet 94% and 62 day performance to meet 80%. DM01 performance to meet 92% by March 2027. UEC performance to be maintained above 98% throughout 2026/27.
2. Sustained reduction in patients waiting over 52 weeks by 1%
3. Completion of service reviews and outcomes (burns - September 2026, prosthetics - October 2026, breast - March 2027)
4. Maintain leading national positions in the adult inpatient survey, children and young people survey and the national cancer patient experience survey
5. Achievement of above the national average for all 8 domains of the Patient-Led Assessments of the Care Environment (PLACE) inspection.

KSO1 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

General summary

Month 6 continues to reflect significant pressure across the Trust's key operational access standards. RTT, diagnostics and a number of cancer metrics remain below trajectory driven by sustained referral growth, capacity constraints and increasing pathway complexity. The greatest operational challenges continue to be within Sleep Services, OMFS and Skin pathways, with diagnostic performance also impacted by pressures within Sleep Diagnostics and Ultrasound services. Despite these challenges, activity levels remain strong, with 352 more clock stops than planned and theatre utilisation increasing to 82.4% supporting delivery of recovery plans aligned to KSO 1 (Outstanding Care).

Alongside operational recovery, the Trust continues to progress key transformation initiatives, including implementation of the Federated Data Platform and development of the Sussex-wide Single Point of Access (SPoA) model. These programmes are expected to support longer-term improvements in pathway management, patient access, productivity and system-wide elective recovery.

Delivery of Access Targets

- The RTT waiting list increased to 22,365 pathways during M6 and remains significantly above plan. Growth continues to be concentrated within Sleep services where referral demand remains above trajectory. In addition, Plastics reported waiting list growth exceeding trajectory by 249. Recovery plans remain focused on increasing activity, clock stops, improving pathway productivity and reducing future waiting list growth.
- The Trust reported 36 patients waiting over 65 weeks and 15 patients waiting over 78 weeks, an improvement from M4. The Breast Reconstruction pathway continues to account for the majority of the remaining cohort (94%) and remains subject to targeted recovery oversight.
- RTT 18-week performance reduced to 60.3% in M6, compared to 60.8% in M5, and remains below the planned trajectory of 63.3%. Whilst clock stop activity is above plan, sustained referral growth at the beginning of the calendar year is impeding recovery gains. Sleep Services, OMFS and CCCS remain below trajectory by over 5%. Recovery actions remain focused on increasing elective throughput, reducing long waits, improving theatre productivity and accelerating specialty recovery plans.
- DM01 performance reported a slight improvement of 0.2%, with a position of 85% against a planned trajectory of 91%. Sleep Diagnostics continues to account for the majority of variance due to sustained referral growth and capacity pressures. However, M6 also saw a decline in Ultrasound performance, with further challenges anticipated over the coming months. Recovery actions are focused on increasing diagnostic capacity, pathway redesign, demand management initiatives and targeted mitigation plans to support delivery of the six-week standard. Wider diagnostic services continue to perform strongly.
- Cancer performance remains challenged but is in a recovering position. The most significant pressure within the Skin and Breast pathways continues to be treatment capacity, whilst delays within the Head and Neck pathway are primarily driven by challenges at the front end of the pathway and access to diagnostics. In addition, follow-up outpatient capacity remains a key constraint across both Skin and Head and Neck services, impacting delivery of the Faster Diagnostic Standard (FDS) and 62-day performance standards. Enhanced governance arrangements, strengthened pathway oversight, and targeted capacity interventions have been implemented to support recovery; however, the 62-day performance is expected to remain below trajectory in the short term whilst these actions take effect.
- Theatre utilisation increased to 82.4% in M6, compared to 80.6% in M5.

Key Risk Summary:

- Continued sustained referral growth within Sleep Services remains the principal risk to delivery of RTT and diagnostic recovery, driving waiting list growth and underperformance against trajectory. Significant RTT pressures continue within Sleep, OMFS and Plastics, whilst cancer performance remains impacted by demand and capacity challenges within Skin, Breast and Head & Neck pathways. Emerging pressures within Ultrasound services due to workforce constraints and continued growth in the 40-51 week waiting cohort present further risks to delivery of year-end trajectories. Successful implementation of specialty recovery plans and capacity interventions will be critical to improving performance during H2 and supporting delivery of KSO 1 (Outstanding Care).

Continued..

KSO1 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Thirlwall Inquiry
The Thirlwall Inquiry Report, published on 15 September 2026, identified significant failures in the escalation and investigation of patient safety concerns, alongside weaknesses in governance, safeguarding, organisational culture and oversight arrangements. The report makes a number of national recommendations to strengthen safeguarding, leadership accountability, speaking-up arrangements and processes for responding to suspected deliberate harm. Its central message is that patient safety must take precedence over organisational or reputational considerations, supported by a culture of early escalation, transparency and professional challenge. The Trust is reviewing the findings and progressing work to assess and implement the relevant recommendations through existing patient safety, safeguarding and governance programmes.

Patient Safety
World Patient Safety Day on September 17th provided an opportunity to showcase QVH's strong and embedded patient safety culture. External feedback highlighted the Trust's commitment to learning, openness, psychological safety and continuous improvement, with patient safety consistently evident across clinical, operational, research and patient experience teams. Particular recognition was given to staff engagement, the shared responsibility for safety, and the effective dissemination of learning to drive improvements in patient care and outcomes.

Friends and Family Test (FFT)
FFT recommendation rates remained consistently high at 95% in Month 6, demonstrating continued positive patient experience and confidence in the care provided at QVH. Overall response rates increased from 11.7% to 12.8%, reflecting the successful embedding of the new FFT provider and ongoing efforts to improve patient engagement and survey accessibility. The increase in responses provides greater assurance that patient feedback is representative and continues to support the identification of opportunities for service improvement while maintaining high levels of patient satisfaction.

Kathy Brasier
Acting Chief Strategy Officer

Liz Blackburn
Acting Chief Nursing Officer

KSO1 BALANCED SCORECARDS

QUALITY & SAFETY METRICS

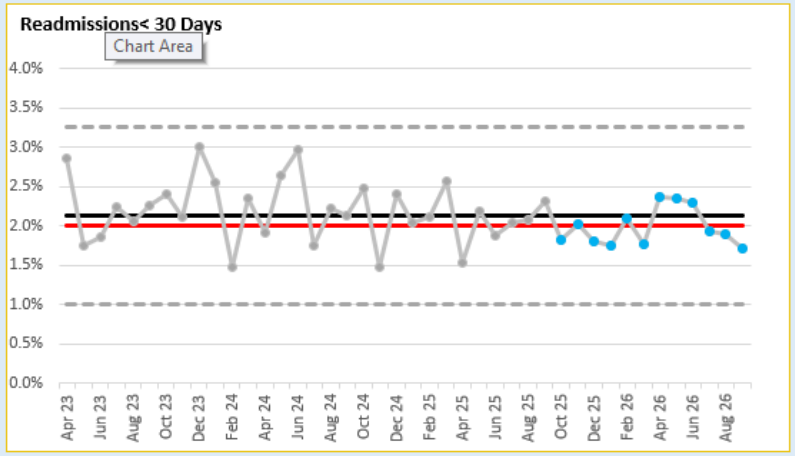
Queen Victoria Hospital
NHS Foundation Trust

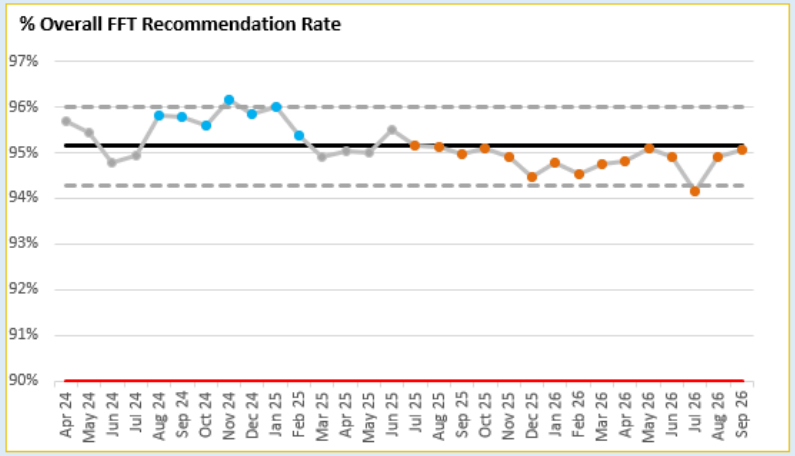
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Variation Summary
Ethnicity recording	Sep-26	95%			83.74%	84.61%	81.77%	79.27%	84.27%	Special Cause - improving variation
Care Hours Per Patient Day (CHPPD)	Sep-26				11.9	10.9	13.05	10.08	16.02	Special Cause - concerning variation
Falls per 1,000 Occupied Bed Days	Sep-26	7			0.0	0.0	3.92	-3.20	11.03	Common cause - no signficant change
Hospital Aquired PU Per 1,000 Occupied Bed Days	Sep-26	0			0.0	0.0	0.72	-1.52	2.96	Common cause - no signficant change
% Complaints Responded On Time	Sep-26	90%			88.89%	60.00%	90.08%	61.46%	118.71%	Common cause - no signficant change
Safer Staffing Compliance	Sep-26	90%			99.75%	99.49%	99.61%	98.45%	100.78%	Common cause - no signficant change
% Overall FFT Recommendation Rate	Sep-26	90%			95.07%	94.91%	95.15%	94.29%	96.01%	Special Cause - concerning variation
% Overall FFT Response Rate	Sep-26	25%			12.80%	11.71%	19.77%	16.05%	23.49%	Special Cause - concerning variation
Readmissions< 30 Days	Sep-26	2%			1.72%	1.90%	2.13%	1.00%	3.26%	Special Cause - improving variation
VTE Risk Assessment	Sep-26	95%			90.26%	92.08%	93.21%	82.96%	103.47%	Common cause - no signficant change

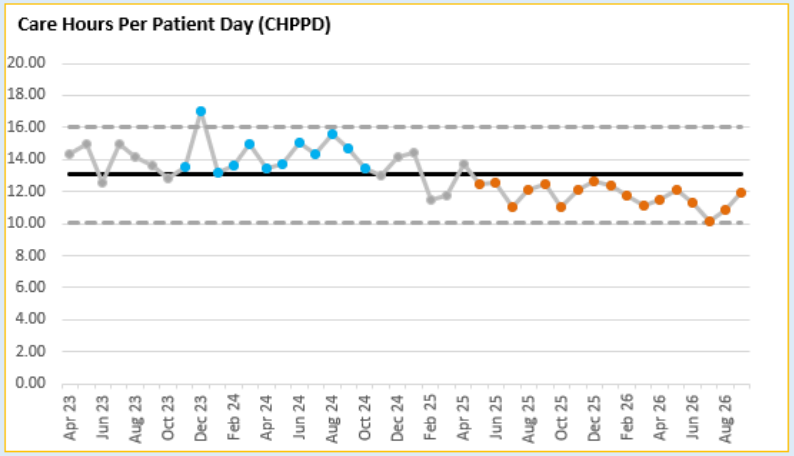
Metric	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Number of Complaints	9	9	9	9	6	6	10	8	9	9	7	8	3	7	12
Number of Open CAS Alerts	1	0	0	0	1	1	2	1	1	1	1	0	0	0	1
Number of Patient Falls Incidents	5	4	1	2	2	2	1	3	1	5	6	6	4	0	0
Number of QVH Acquired Pressure Ulcers Cat. 2 and above	1	1	1	0	0	0	0	0	1	1	1	1	0	0	0
Never Events declared	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Medication Incidents (No and low harm)	15	12	12	4	10	10	16	35	31	27	16	26	18	16	12
Medication Incidents (Moderate harm or above)	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Internal Investigation declared	0	1	0	0	0	1	1	0	0	0	0	1	0	1	0
Patient safety incident investigations declared	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mortalities	1	0	0	0	0	0	0	0	0	0	0	0	2	0	0
Hospital Acquired CDI, MRSA, E.Coli, MSSA	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Occupied Bed Days	933	704	739	860	778	676	799	721	821	806	738	838	941	817	777
Oliver McGowan Training Compliance	92.2%	92.4%	92.9%	92.4%	93.1%	93.1%	93.7%	93.3%	93.6%	93.9%	94.0%	94.3%	94.6%	95.3%	94.2%

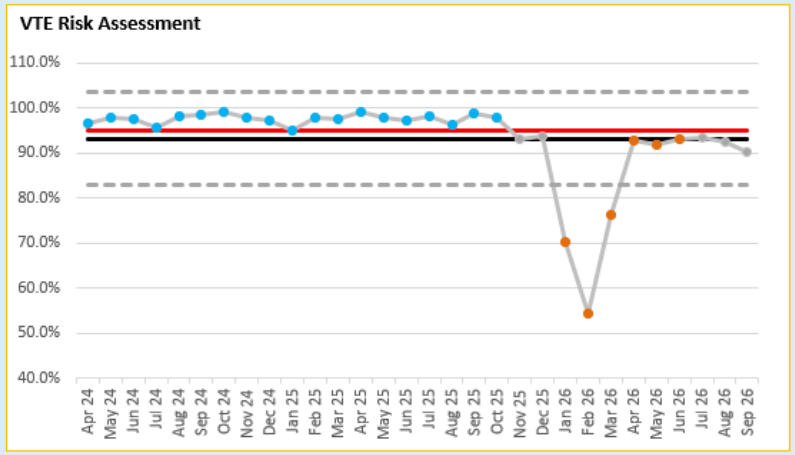
QUALITY & SAFETY METRICS

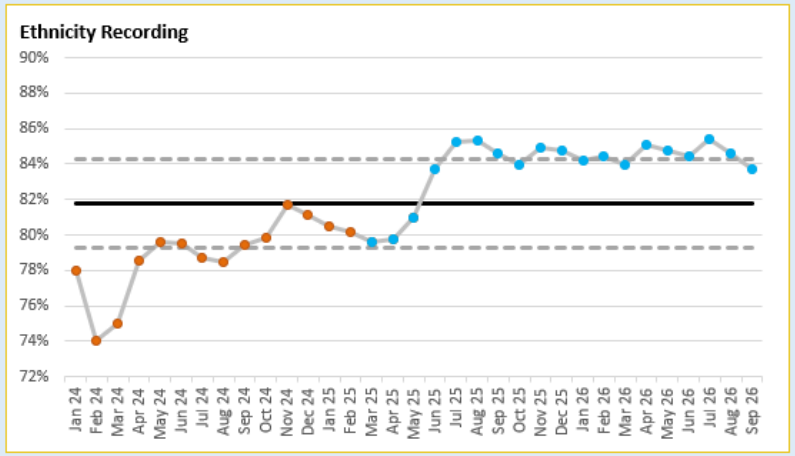
Queen Victoria Hospital
NHS Foundation Trust











Safer Staffing Compliance - Trust

	Planned staff			Actual staff			September 2026
DAY	RN	NA	HCA	RN	NA	HCA	
	3,651.25	69.00	1,414.50	3,628.25	69.00	1,414.50	*Total Hrs Planned and Actual*
				99.4%	100.0%	100.0%	*% Planned Hrs Met*
			5,134.75			5,111.75	*Total Hrs Planned & Actual - Combined reg & support*
						99.55%	*% Planned Hrs Met - Combined reg & support*
NIGHT	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
	3,105.00	46.00	966.00	3,105.00	46.00	966.00	*Total Hrs Planned and Actual*
				100.0%	100.0%	100.0%	*% Planned Hrs Met*
			4,117.00			4,117.00	*Total Hrs Planned & Actual - Combined reg & support*
						100.00%	*% Planned Hrs Met - Combined reg & support*
Combined	Planned staff			Actual staff			
	RN	NA	HCA	RN	NA	HCA	
	6,756.25	115.00	2,380.50	6,733.25	115.00	2,380.50	*Total Hrs Planned and Actual*
				99.7%	100.0%	100.0%	*% Planned Hrs Met*
			9,251.75			9,228.75	*Total Hrs Planned & Actual - Combined reg & support*
						99.75%	*% Planned Hrs Met - Combined reg & support*

SPC Chart Key:

- Mean
- Target
- Process limits
- Special cause - concern
- Special cause - improvement

KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact, and actions
Ethnicity Recording	• Performance reduced from 85.4% in M5 to 83.74% in M6, mainly due to lower completion rates in Plastics and Oral & Maxillofacial Surgery (OMFS). Targeted actions are in place, including specialty engagement, performance monitoring, and strengthened ethnicity data capture processes, with progress being closely tracked.
Falls	• Zero falls in month, terms of reference approved for Falls Oversight Group.
Pressure ulcers	• Zero pressure ulcers in month. Review of mattresses within the Trust.
% Complaints Responded On Time	• 12 complaints were received in Month 6. Compliance with complaint response times improved significantly, increasing from 60% to 89%, reflecting continued focus on timeliness and responsiveness in complaint handling.
Safer Staffing Compliance / Care Hours Per Patient Day (CHPPD)	• Safer staffing compliance and fill rates remained high at 99.7% in Month 6. Care Hours Per Patient Day increased from 10.9 in Month 5 to 11.9 in Month 6, reflecting the specialist nature of the Burns service alongside lower bed occupancy during the month.
Never Events	• Zero Never events in month.
Mortalities	• Zero mortalities in month.
% Overall FFT (Friends & Family Test) Recommendation Rate	• FFT recommendation rates remained high at 95% in Month 6. Overall response rates increased from 11.7% to 12.8%, reflecting the continued embedding of the new FFT provider and improved patient engagement with the survey process.
Venous Thromboembolism (VTE) Risk Assessment	• VTE assessment compliance remained at 90% in Month 6, demonstrating sustained improvement, however, performance continues to be below the Trust target of 95%. Ongoing actions are in place to further strengthen compliance and support achievement of the target.
Mental Capacity Act (MCA)	• There has been continued improvement in compliance with recording and evidencing Lasting Power of Attorney (LPA) arrangements, with increased documentation uploaded to patient records. The number of capacity assessments completed on the day of surgery has reduced following the implementation of Task and Finish Group recommendations. Development of mandatory Mental Capacity Act (MCA) training for surgeons is progressing, alongside ongoing bespoke training across clinical services.

KSO1 BALANCED SCORECARDS

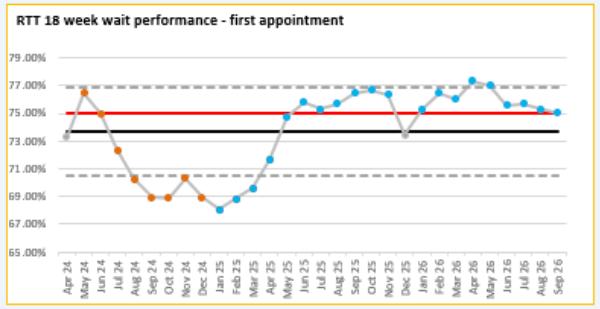
Queen Victoria Hospital
NHS Foundation Trust

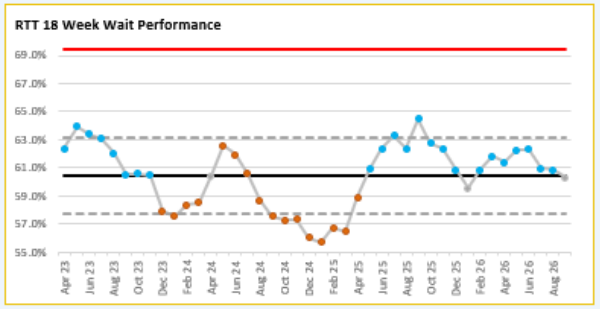
OPERATIONAL PERFORMANCE METRICS

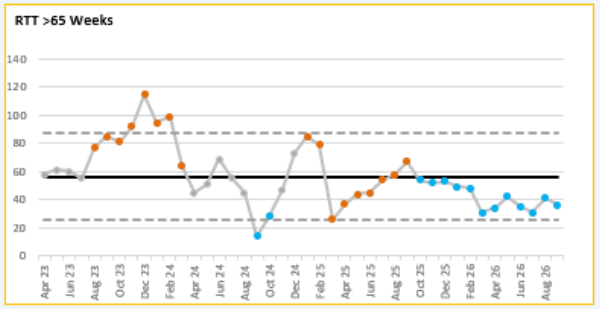
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Variation Summary
RTT 18 week wait performance - first appointment	Sep-26	75.00%			75.01%	75.33%	73.84%	70.57%	77.12%	Special Cause - improving variation
RTT 18 Week Wait Performance	Sep-26	69.40%			60.30%	60.86%	60.52%	57.76%	63.27%	Common cause - no signficant change
RTT Waiting List	Sep-26	-			22,365	22,255	19042.95	18283.42	19802.48	Special Cause - concerning variation
RTT >40 Weeks	Sep-26	-			1,435	1,465	1422.68	1256.40	1588.97	Common cause - no signficant change
RTT >52 Weeks	Sep-26	-			257	228	366.12	295.39	436.85	Special Cause - improving variation
RTT >52 Weeks as a proportion of Waiting List	Sep-26	1.00%			1.15%	1.02%	1.96%	1.61%	2.31%	Special Cause - improving variation
RTT >65 Weeks	Sep-26	-			36	41	57.46	27.79	87.13	Special Cause - improving variation
% CDC VWA vs plan	Sep-26	100.00%			94.35%	96.46%	91.20%	79.49%	102.91%	Common cause - no signficant change
% VWA vs plan	Sep-26	100.00%			105.11%	103.98%	100.85%	85.44%	116.26%	Common cause - no signficant change
Cancer 28 Day FDS	Aug-26	81.50%			58.60%	57.69%	79.96%	66.88%	93.04%	Special Cause - concerning variation
Cancer 31 Days	Aug-26	94.00%			89.14%	89.17%	86.17%	76.29%	96.04%	Common cause - no signficant change
Cancer 62 Days	Aug-26	80.00%			75.00%	75.92%	77.03%	62.67%	91.39%	Common cause - no signficant change
Outpatient Productivity - Patient Initiated Follow Ups (PIFU)	Sep-26	2.00%			2.37%	2.31%	1.83%	1.37%	2.29%	Special Cause - improving variation
Outpatient Productivity - Missed Appointment Rate	Sep-26	4.00%			5.60%	5.62%	5.20%	3.81%	6.58%	Common cause - no signficant change
Diagnostics 6 Week Wait Performance	Sep-26	92.00%			85.00%	84.85%	86.33%	78.90%	93.76%	Common cause - no signficant change
UEC 4 Hour Performance	Sep-26	98.00%			99.93%	100.00%	99.21%	97.73%	100.69%	Common cause - no signficant change
Theatre Productivity - % of Cancellations on the Day	Sep-26	5.00%			4.65%	4.46%	4.94%	1.19%	8.70%	Common cause - no signficant change
Theatre Elective Utilisation - QVH Site (Capped)	Sep-26	85.00%			82.40%	80.62%	82.07%	77.46%	86.67%	Common cause - no signficant change
NHS App appointments available	Sep-26	70.00%			84.78%	84.23%	84.71%	83.15%	86.27%	Common cause - no signficant change

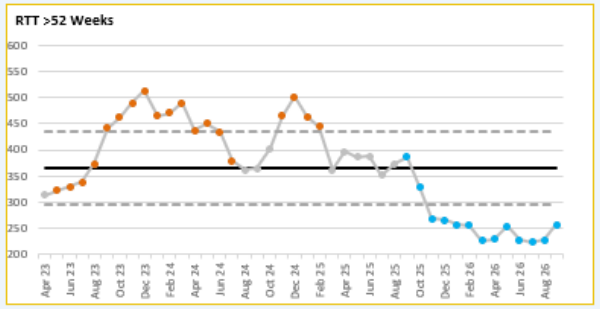
OPERATIONAL PERFORMANCE METRICS

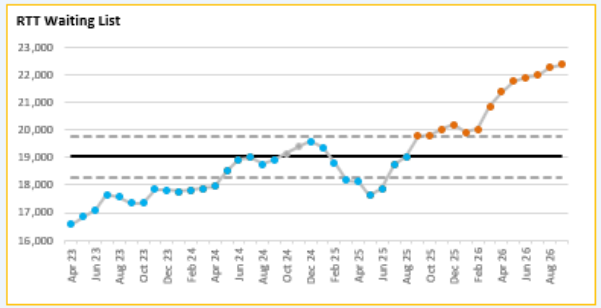
Queen Victoria Hospital
NHS Foundation Trust

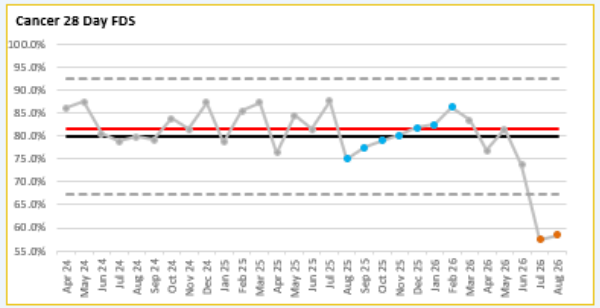


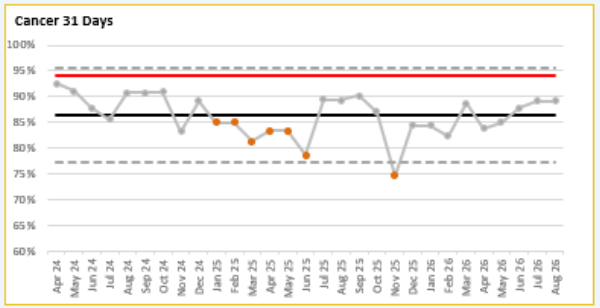


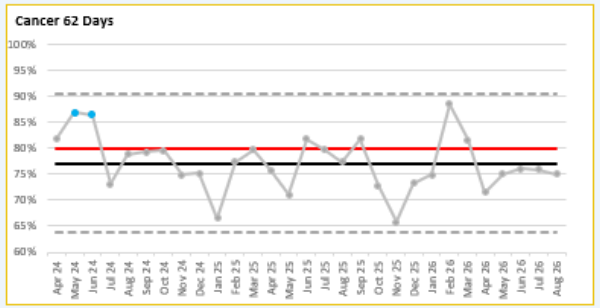


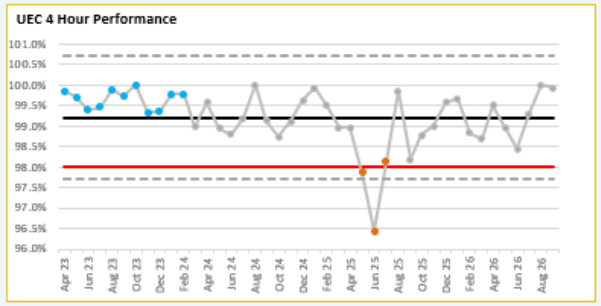


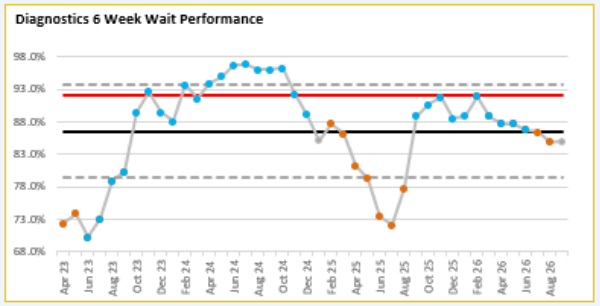


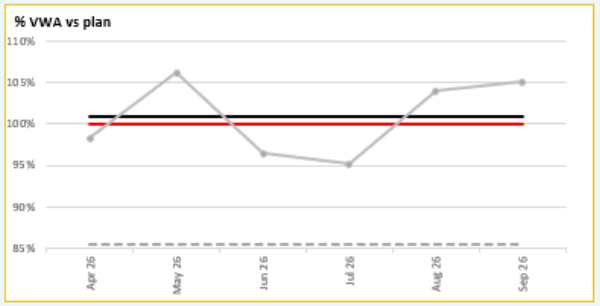


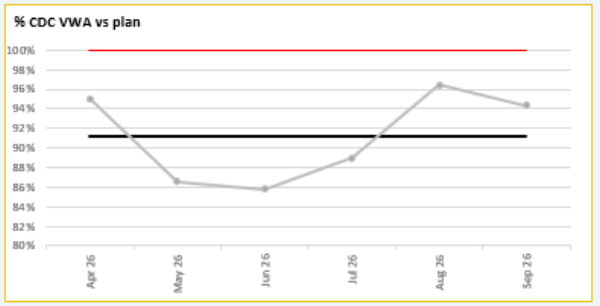












Benchmarking - Operational performance

Queen Victoria Hospital
NHS Foundation Trust

Group	Metric	Value	Latest Month	Specialist Rank	Specialist Rank (out of)	England Rank	England Rank (out of)
A&E / Minor Injury Unit	All 4 Hour Waits Performance	99.93%	Sep-26	1	3	1	138
Cancer Treatment	FDS Performance	58.60%	Aug-26	10	12	129	132
	31 days Performance	89.14%	Aug-26	13	13	116	134
	62 days Performance	75.00%	Aug-26	9	13	61	133
Diagnostics (DM01)	Under 6 Weeks Performance	84.85%	Aug-26	11	13	56	153
Referral To Treatment	Within 18 Weeks Performance	60.86%	Aug-26	13	13	119	145
	Percentage over 52 weeks	1.02%	Aug-26	10	13	80	145

Source: *NHS England Statistical Work Areas website; NHS Trusts Only - 'Community and Mental Health', 'Acute' & 'Specialist' English patients only so will be a sub-set of actual Trust performance figures (apart from A&E)*

KSO1 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Month Plan	Summary, impact and actions
Referral to Treatment (RTT) > 65 week waits	-	• The Trust reported 36 patients waiting over 65 weeks, a decrease of 5, with 15 patients waiting over 78 weeks, an increase of 2. Of the 36 patients over 65 weeks, 5 were non breast reconstruction patients (x2 skin, x1 hands and x2 OMFS). Of the 15 over 78 weeks, 1 was a non-breast reconstruction patient (x1 OMFS – late referral from Medway Maritime Hospital (MMH) Ear Nose and Throat (ENT) at 72wks). • Weekly review, targeted validation, prioritised scheduling and additional theatre capacity remain in place to support delivery of recovery trajectories.
RTT>52 week waits	210	• The number of patients waiting over 52 weeks increased to 257 patients in M6, compared to 228 in M5 (increase of 29). Performance remains above the planned trajectory by 47, with Plastics and OMFS remaining above plan. • Plastics continues to account for the largest proportion of the >52-week cohort; within Plastics 49% are breast reconstruction, however the non-breast reconstruction patients reported an increase of 17, driven by Skin (+14) and Dermatology (+5). Of the 180 Plastics patients; 88 have a treatment booked, 76 are awaiting scheduling, 11 have a next outpatient (OP) activity, whilst 5 have a next OP activity pending. • OMFS remains the second-largest contributor, although performance remained stable during M6. • Recovery actions include targeted waiting list reviews, additional theatre capacity, improved theatre productivity, workforce recruitment, enhanced specialty-level oversight of patients approaching long-wait thresholds and close management of the 40-51 week cohort.
RTT 18 Week Wait Performance	63.3%	• RTT performance reduced to 60.3% in M6, 3.0% below trajectory and 0.5% lower than M5. The number of patients waiting over 18 weeks increased by 169 to 8,880. • The main pressures continue to be within Sleep and OMFS, driven by increased demand earlier in the calendar year, with these referrals now breaching the 18-week standard. • Despite these challenges, clock stop activity remained above plan across all specialties except CCCS, with the Trust delivering 352 more clock stops than planned in M6. • Recovery efforts remain focused on improvement plans, additional activity, pathway validation, and strengthened operational oversight.
RTT Waiting List	20,603	• The waiting list increased to 22,365 in M6, an increase of 110 from M4, and remains significantly above the planned trajectory. Growth continues to be concentrated within Sleep Services, which accounts for the majority of the overall variance, alongside continued pressures within Plastics. Referral volumes within Sleep continue to exceed planned assumptions and are outpacing recovery gains despite increased activity and productivity initiatives. • Discussions remain ongoing with commissioners and system partners to explore Sleep referral and pathway options, including QVH becoming a hub and spoke model within Sussex. In parallel, specialty recovery plans continue to focus on increasing activity, improving pathway productivity and mitigating the impact of sustained demand growth on waiting list performance.
Cancer 28 Day FDS (Faster Diagnostic Standards)	80.8%	• FDS performance remained significantly below trajectory in M5, with the principal challenges continuing to be within the Skin pathway. Performance was impacted by outpatient capacity constraints. Skin performance was further affected by teledermatology process challenges and reduced face-to-face clinic capacity. • Recovery actions have been successful with performance now back on plan, with M6 performance reporting above 80% and achieving trajectory, with all specialties hitting plan. M7 is also achieving trajectory. • The weekly USC capacity meeting continues with senior leadership oversight, providing a forward-looking review of demand, capacity, and emerging risks to support timely intervention and delivery of pathway performance.
Cancer 31 Days	87.6%	• 31-day performance remains above trajectory in M5, with significant improvements reported within Skin. However, demand for cancer treatment continues to remain high. Theatre capacity constraints for the complex surgeries, in particular Breast Immediate, Skin SLNB and Head and Neck major cases, remain the principal operational risk. • M6 performance is remaining on trajectory. • Plans focus on prioritisation of cancer activity, and additional capacity where available.

KSO1 AREAS OF FOCUS

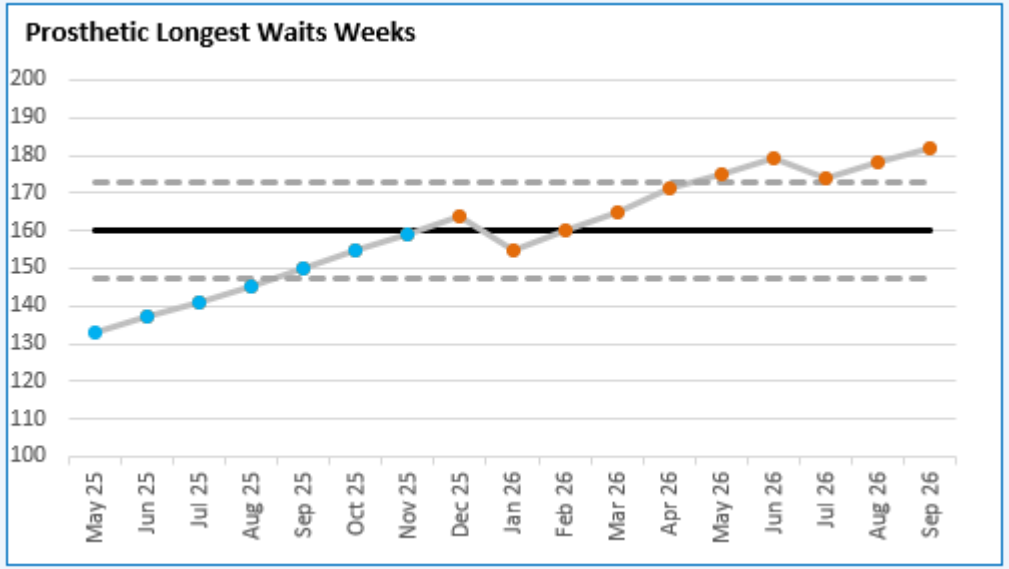
Queen Victoria Hospital
NHS Foundation Trust

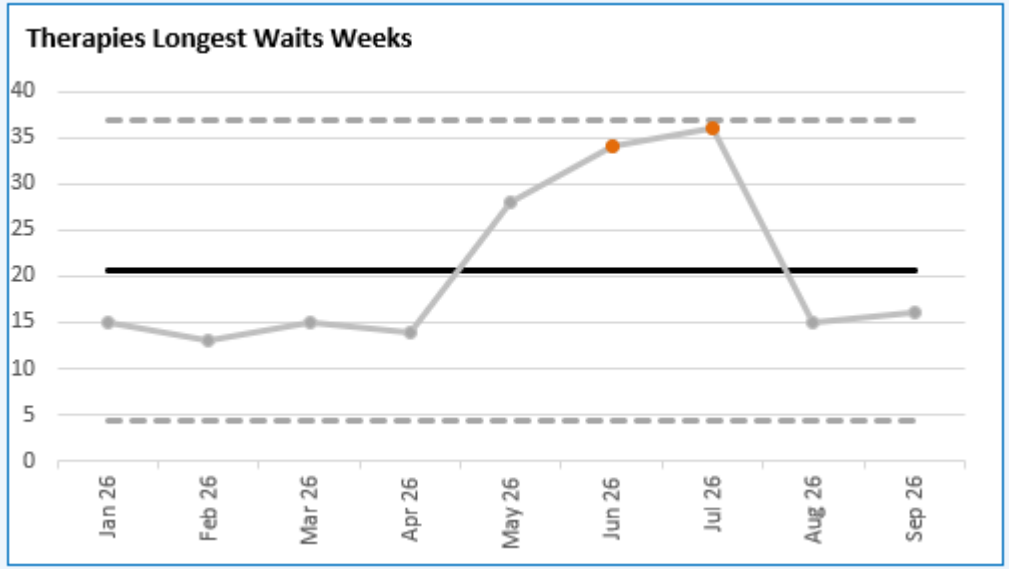
Area	Month Plan	Summary, impact and actions
Cancer 62 Days	73.6%	• 62 Day performance achieved trajectory in M5. Skin was the largest impact pathway (-7.4 percentage points). M6 is not expecting to achieve trajectory. • The principal driver of Skin performance continues to be sustained growth in tertiary referrals from Kent Integrated Dermatology Service (KIDS) to the Medway Spoke Site, with demand running at 167% of the level seen last year. • Additional factors affecting recovery include limited follow-up capacity, particularly for breaking bad news appointments, diagnostic delays at the Spoke Sites for Head and Neck patients, and theatre capacity constraints for complex consultant-led cases across Breast, Head and Neck, and Skin pathways. • A key focus for M7-M8 is the full transition to an action-based tracking approach within the Trust's Somerset Cancer Register (SCR). This will strengthen the escalation and management of patients at risk of breaching standards, while supporting a more systematic review of recurring pathway delays and tracking themes to enable earlier intervention and service improvement.
Diagnostics 6 Week Wait Performance	91.0%	• DM01 performance reported an increase of 0.2%, with a position of 85% against a trajectory of 91% during M6. Sleep Diagnostics remains the principal driver of underperformance due to sustained referral growth, increasing waiting list pressures and capacity constraints. M6 also reported a further reduction in Ultrasound performance, with further operational challenges anticipated over M7 and M8. • Recovery actions include expansion of home testing pathways, review of diagnostic capacity, pathway redesign, demand management initiatives and targeted mitigations within Ultrasound services. Wider diagnostic services continue to perform strongly and remain broadly compliant with expected standards.
% Community Diagnostic Centre (CDC) Value Weighted Activity (VWA) vs plan	100%	• CDC activity remained below plan in Month 6, delivering 3,276 tests against a plan of 3,611 (90.7%) but much higher than 2,809 delivered in Month 5. • Value Weighted Activity (VWA) achieved 94.4% of plan £314k against £333k. • Strong over-performance seen in Telederm (138%), DEXA, MRI diagnostics, Full Pulmonary Function Testing helping offset underperformance in electrocardiogram (ECG) , Spirometry, FeNO and Phlebotomy. • Sleep Studies remained close to plan at 95%, demonstrating sustained recovery compared to earlier in the year. Recovery actions continue to focus on increasing activity and utilisation and aim to recover the YTD activity shortfall in H2. • Ultrasound activity remains challenged due to existing and incoming Sonographer vacancies
Theatre capped utilisation		• Theatre utilisation improved from 80.6% in August to 82.4% in September sustaining positive performance trends. • Surgical activity remained high at 1,188 procedures, maintaining the significant gains achieved since the implementation of Archie. • On-the-day cancellations remained below the Getting it Right First Time (GIRFT) threshold at 4.7%, while the standby patient pathway enabled 12 patients to be treated in month and a total of 45 patients since June, helping to maximise theatre capacity and reduce lost operating time. • The introduction of the 08:45 theatre start-time trial contributed to improved list starts.
Minor Injuries Unit (MIU) 4 Hour Performance	98.0%	• MIU performance achieved 99.9%, remaining above trajectory and continuing a sustained period of strong performance. No significant operational issues have been identified, and performance is expected to remain stable.
% Value Weighted Activity (VWA) vs plan	105.11%	• VWA exceeding plan for M6, primarily reflecting overperformance within Sleep and Plastics elective. Historical trends continue to demonstrate significant improvement following completion of coding and cashing-up processes and therefore further movement in the reported position is possible.

KSO1 BALANCED SCORECARD

Queen Victoria Hospital
NHS Foundation Trust

OPERATIONAL PERFORMANCE METRICS - Prosthetics and Therapies



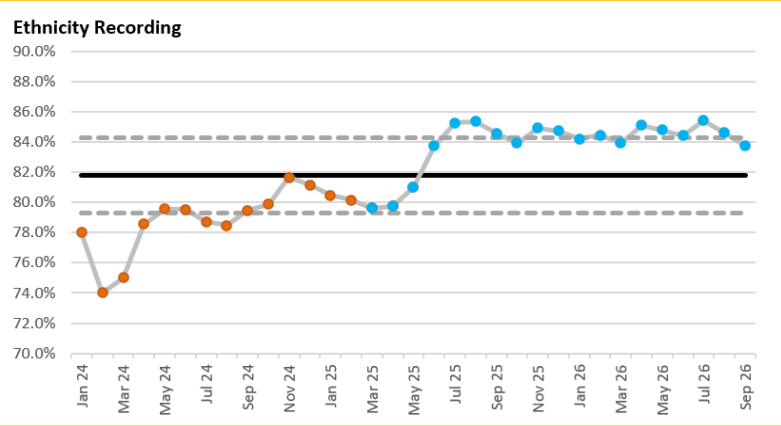


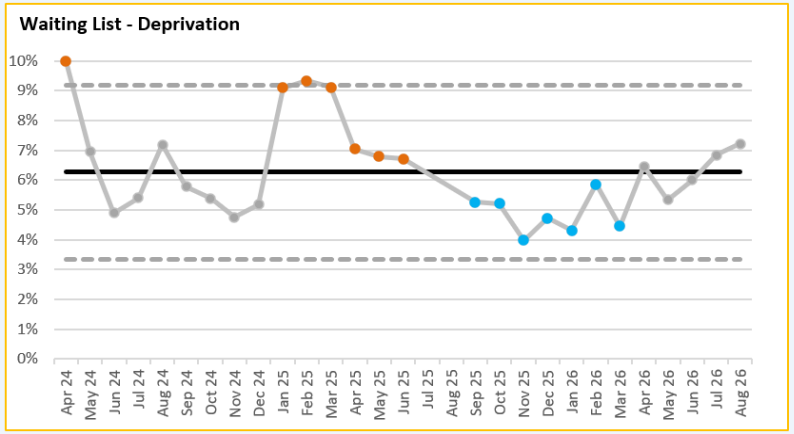
Area	Summary, impact and actions
Non-RTT Prosthetics longest week waits	At M6 there are 84 patients on the Waiting list (for prosthetic treatment/new device) and 73 patients on the Care list overdue for a review/revision appointment down from 73 last month (Care list total is 236 patients). The waiting list is reviewed for clinical priority patients weekly, and patients are signposted to relevant charities for access additional support.
Non-RTT Therapies longest week waits	At the end of Month M6, the Trust had 402 patients on the waiting list for a first consultation within therapist led clinics (an increase of 29 from M5), with the longest wait at 16 weeks (significant drop from 36 weeks in M4) as a result of appropriate temporary staffing and waiting list initiatives. Looking forward this surplus demand will be sustainably addressed when new starter is in post from Mid-October bringing SLT up to its full establishment.

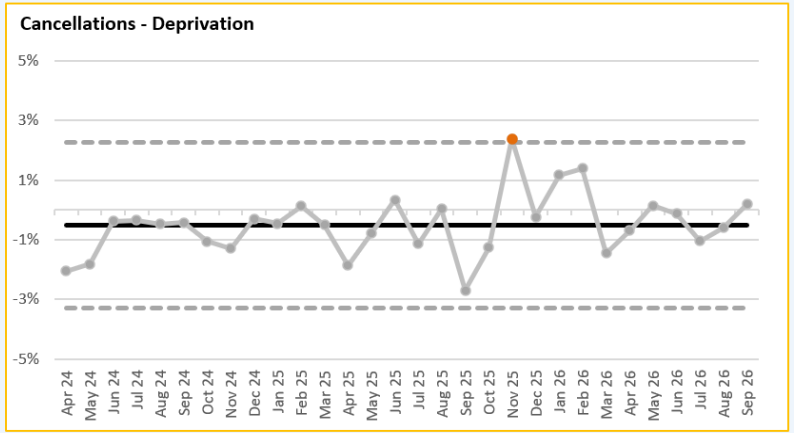
HEALTH INEQUALITIES PRIORITY PROGRESS

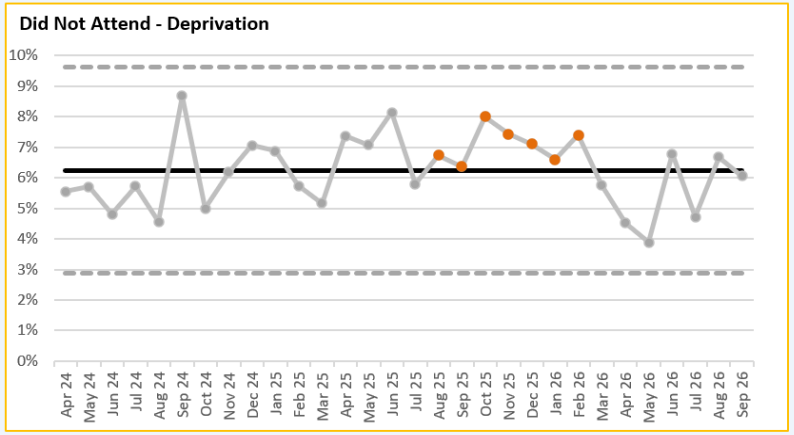
Queen Victoria Hospital
NHS Foundation Trust

Note that there are data quality issues with these metrics - Ethnicity is not known for new patients until they attend site and the Index of Multiple Deprivation depends on up-to-date post code information and mapping.









Metric - Sep-26	Black (M, N, P)	White (A, B, C)	Asian (H, J, K, L)	Mixed (D, E, F, G)	Other (R, S)	Not Assigned	Total
Did Not Attend - Ethnicity Groups rolling 6 months	9.48%	4.60%	6.44%	6.78%	6.64%	8.89%	5.51%

Area	Summary and actions
Ethnicity Data Improvement	Performance reduced from 85.4% in M5 to 83.74% in M6, mainly due to lower completion rates in Plastics and OMFS. Improvement efforts continue to focus on areas with the largest gaps (Plastics, OMFS, Therapies), standardising key processes, establishing clear ownership and monitoring, and providing guidance, training, and communication support.
Waiting List / Deprivation Variation	Mapping of Index of Multiple Deprivation (IMD) deciles to the RTT PTL remains ongoing. Following the pause of the PAS project, an options paper has been submitted (Oct) to assess whether implementation of the UPM (Unified Pathway Manager) should also be deferred. The consultant review process has now been completed and formalised through an SOP. The SOP is scheduled for review by the Access and Responsiveness Committee in October (28/10).
Patient-led Cancellations / Deprivation Variation	To continue to focus on establishing a dedicated patient cohort within the new Unified Pathway Manager (UPM) to identify patients from areas of high deprivation who have repeatedly DNA'd or cancelled appointments. The aim is to proactively contact these patients to better understand any barriers to attendance and explore what support can be provided to improve access and reduce non-attendance. This approach would apply to both RTT and non-RTT patient pathways.
DNA / Deprivation Variation	
DNA / Ethnicity Variation	

KSO2

To innovate and improve

Ambition

To reflect our future commitment and aspiration to research, innovation and continuous improvement underpinning all that we do

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

2026/27 Annual Objectives

1. Research, Innovation & Education Centre and strengthen academic and commercial partners
2. Ensure the QVH Way underpins all improvement and transformation programmes

2026/27 Annual goals

1. Delivery of Research & Innovation strategic plan year 2
2. Delivery of a Continuous Improvement (CI) in-house targeted training programme

KSO2 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Research, Innovation & Education (RI&E) Centre, Strengthen academic and commercial partners:

The Research, Innovation and Education Centre Task and Finish Group remains on track. Following the internal engagement session, further sessions have been arranged with wider stakeholders and system partners to ensure that their feedback is incorporated into the co-design of the proposed internal space.

The University of Sussex pre-clinical study has now completed with plans to take this to next stage and apply for further funding to continue this development. Discussion Is underway with partners at the university to craft a collaborative next bid.

Recruitment to fill potential vacancies within the Research team has been successful with internal development of two members of our current team leading to successful application and promotion to new roles. Further recruitment is underway to fill the now vacant posts left by these promotions ensuring the establishment remains complete whilst developing opportunities for new talent and ensuring that our small team remains as resilient as possible.

The National Institute for Health and Care Research (NIHR) / Research Delivery Network (RDN) opened a Contingency funding call to which a QVH bid was submitted for £33k of in-year (non-recurrent) funding – we await news as to whether we have been successful in this bid which will be effective from November 2026.

The 2027 NIHR Strategic funding call is now open with plans underway to optimise our opportunities for success. Regular meetings already in progress with key stakeholders across both Royal Surrey County and Ashford and St Peters Hospitals to collaborate around group bids to support Research and Innovation into 2027/28. Ideas generated are complementary and cross-cutting to ensure that a collaborative focus remains the golden thread running through each of our respective bids. This not only supports the bid requirements for this funding call but also mirrors our Strategy ensuring that we meet our own partnership ambitions and system wide desire for collaborative research growth.

Tamara Everington
Chief Medical Officer

KSO2 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

The QVH Way underpins all improvement and transformation programmes:

Continuous Improvement activity through the QVH Way remains embedded across the organisation, with teams using daily huddles to identify and implement practical improvements. Recent examples include the Learning and Development team introducing a mobile-friendly online course evaluation form, reducing paper use and enabling more effective analysis of feedback, and the Radiology team enhancing the waiting area environment to improve accessibility, inclusivity and dementia-friendliness. Early patient feedback has demonstrated a positive impact on the changes made. Regular Huddle Leads Community of Practice meetings continue to support shared learning, enabling teams to exchange successes, challenges and improvement ideas.

The profile of Continuous Improvement remains strong both locally and nationally. The Associate Director of Research, Innovation and Improvement continues to contribute to national improvement networks and recently participated in a national discussion with NHS leaders on approaches to organisational improvement. Locally, World Patient Safety Day provided an opportunity to promote the use of improvement methodology to support patient safety priorities and identify further opportunities for improvement.

In addition, engagement with strategic partners is being strengthened, with plans underway to host a Group Improvement Leads Summit at QVH to share learning, explore common priorities and identify opportunities for future collaboration

Medical Education and Library:
Resident doctors' inductions have now been completed for 2026. The next induction will be February 2027. The team is in the process of reviewing processes around induction, particularly relating to IT and systems access.

Recruitment for the new Specialty, Associate Specialist, and Specialist doctors (SAS) Lead is nearing completion; and the recruited SAS doctor will be in post shortly.

The action plans for the General Medical Council (GMC) survey of resident doctors in training have been reviewed and are in progress. A report on the OMFS action plan will be submitted to NHSE.

A lecture evening is planned for 1st December, with Patrik Lassus from Helsinki University Hospital attending to speak on face transplantation. All staff are welcome to attend.

Recent library statistics show that month on month, the team are processing nearly double the number of article requests when compared to 2022/23. It is reassuring to see that the library service is well used and appreciated by staff.

Tamara Everington
Chief Medical Officer

KSO3

To be an excellent employer

Ambition

Our people are our greatest asset and we need to work hard to develop and deliver our workforce for the future.

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

Queen Victoria Hospital
NHS Foundation Trust

2026/27 Annual Objectives

1. Enhance inclusive collaborative culture including behaviours framework and speaking up (EDI)
2. Develop Trust and directorate leadership capability

2026/27 Annual goals

1. Maintain or improve performance against workforce metrics, including 90% completion of staff appraisal
2. >95% compliance with Resident Doctor 10-point plan
3. People Pulse Survey
4. Annual measurement of: Staff Survey, Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) and update on Cultural diagnostic assessment

KSO3 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

General summary

Month 6 workforce numbers are slightly above plan, with substantive staffing at 1067.75 whole time equivalent (WTE), which is 3.83 WTE above the plan of 1063.92 WTE. Vacancy levels have increased to 0.99%, due to an increase in leavers in September. Additional controls are in place for recruitment approval. Time to hire has increased in M6 to 29.57 days (from 27.78 days) due to planned advance medical starters and occupational health clearances.

Sickness absence remains just above 4%, with continued “concerning variation” across Theatres, Radiography, and Canadian Wing. Drivers in M6 continue to be gastrointestinal problems, with a spike in seasonal illness (cold, cough, flu – influenza) and headaches/migraines alongside other musculoskeletal (MSK) issues, with administrative and nursing staff groups continuing to be most affected, however the trajectory is improving. Agency usage has increased to 9.96 WTE, primarily in Perioperative Services specifically in Day Surgery, Recovery and Theatres, due to additional activity and covering sickness. There was a decrease in bank usage (66.39 WTE) across most directorates.

Turnover has marginally increased from 11.45% to 11.78% in M6. No grievances were raised . Mandatory training compliance has increased to 91.39%, with escalation through the executive monthly dashboard.

Inclusive Collaborative Culture

The Organisational Development & Learning (OD&L) continue to support managers across the organisation. Staff Survey 2026 work is underway with local questions being added for QVH around speaking up and leadership visibility. NHSS26 launched 5 October and will close on 27 November 2026. OD work is ongoing with a series of interventions to support team working underway, this includes supporting culture improvement and team dynamics. Coaching support is being provided to support leaders across a number of teams. Behaviour framework workshops continue to be delivered. Micro-aggression training is being piloted to the Executive Leadership Team and Human Resources before consideration of a further rollout.

Leadership Capability

Change workshops, coaching skills for managers, appraisal training and Managers Essentials Programme continue to be delivered. Oliver McGowan face to face Tier 2 training is progressing with 34.3% of staff who require the training having completed it to date. QVH has reached the threshold target for Sussex of 30% ahead of schedule. Tier 1 dates started delivery in September 2026 and compliance is 17%. The new NHS Leadership and Management framework was launched, and work is being undertaken to rollout the framework.

Helen Edmunds
Chief People Officer

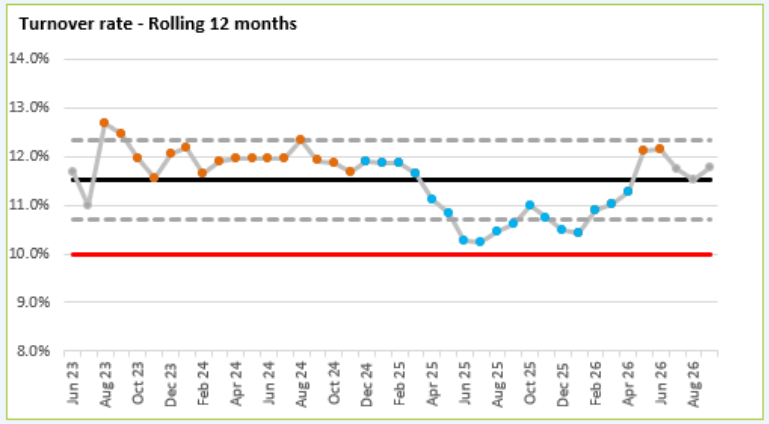
KSO3 BALANCED SCORECARD

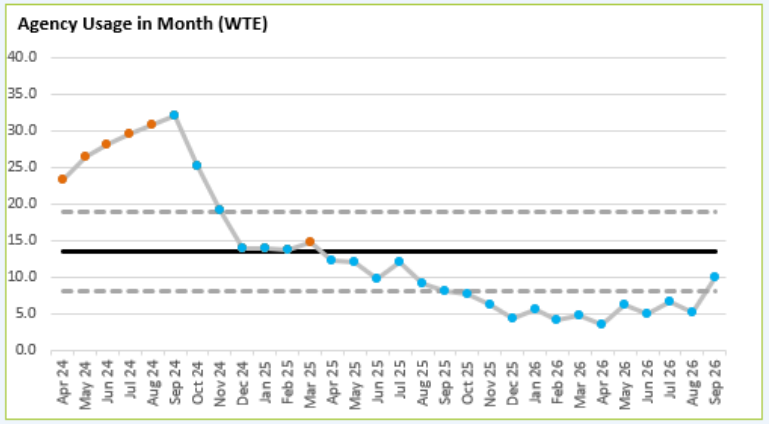
Queen Victoria Hospital
NHS Foundation Trust

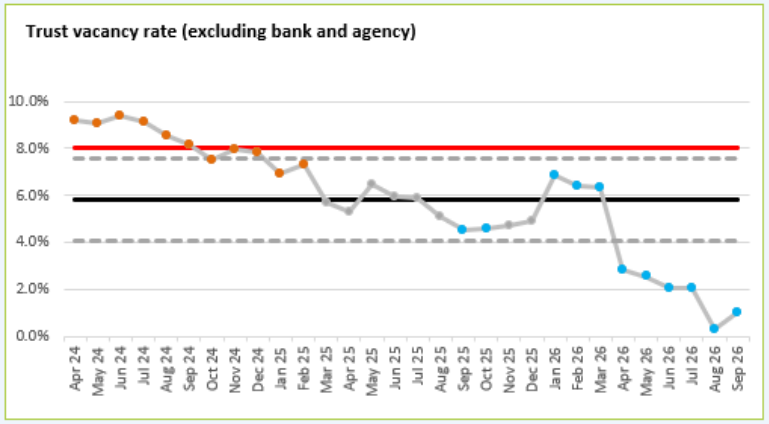
Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Variation Summary
Trust vacancy rate (excluding bank and agency)	Sep-26	8.0%			0.99%	0.29%	5.81%	4.07%	7.55%	Special Cause - improving variation
Vacancies - Incl Bank & Agency	Sep-26	8.0%			-1.07%	-1.86%	1.53%	-0.54%	3.60%	Special Cause - improving variation
Average Time to Hire - Days	Sep-26	53.0			29.57	27.57	51.02	22.05	79.99	Special Cause - improving variation
Turnover rate - Rolling 12 months	Sep-26	10.0%			11.78%	11.45%	11.52%	10.70%	12.33%	Common cause - no signficant change
Sickness absence rate - Rolling 12 months	Sep-26	3.9%			4.33%	4.39%	3.97%	3.85%	4.08%	Special Cause - concerning variation
Appraisal Rate	Sep-26	90.0%			84.56%	86.27%	83.79%	80.89%	86.69%	Common cause - no signficant change
Statutory & Mandatory Training Compliance	Sep-26	90.0%			91.39%	90.75%	91.70%	90.43%	92.97%	Special Cause - concerning variation
Agency Usage in Month (WTE)	Sep-26	-			9.96	5.14	13.44	7.99	18.89	Special Cause - improving variation
Bank Usage in Month (WTE)	Sep-26	-			66.39	72.49	74.44	57.23	91.64	Special Cause - improving variation
Annual Leave Taken	Sep-26	-			47.49%	40.49%	44.21%	11.34%	77.08%	Special Cause - improving variation

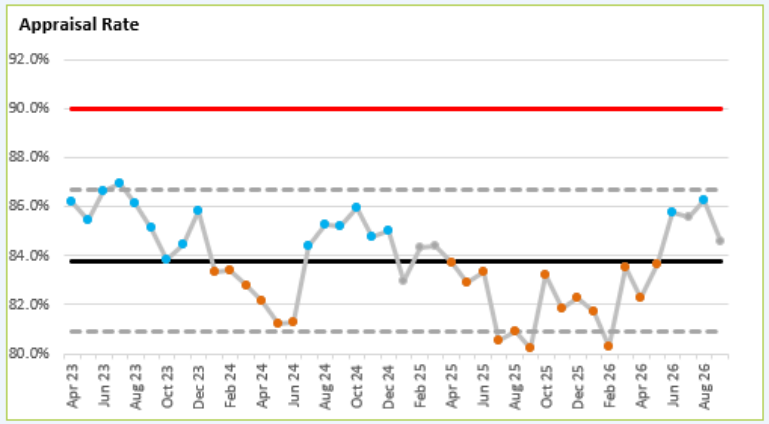
EXCELLENT EMPLOYER KEY METRICS

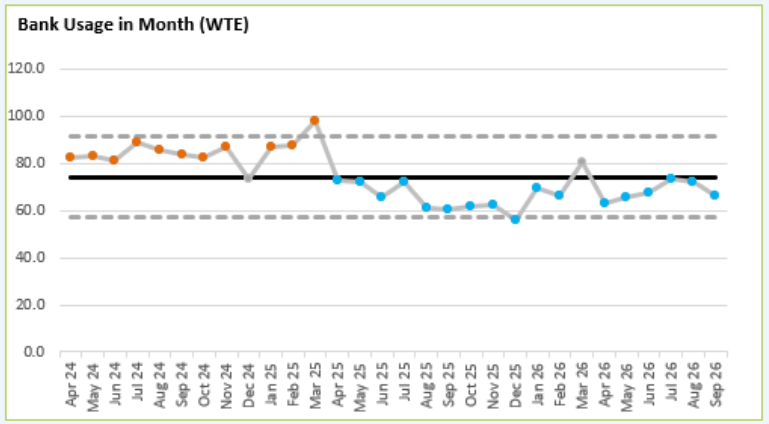
Queen Victoria Hospital
NHS Foundation Trust

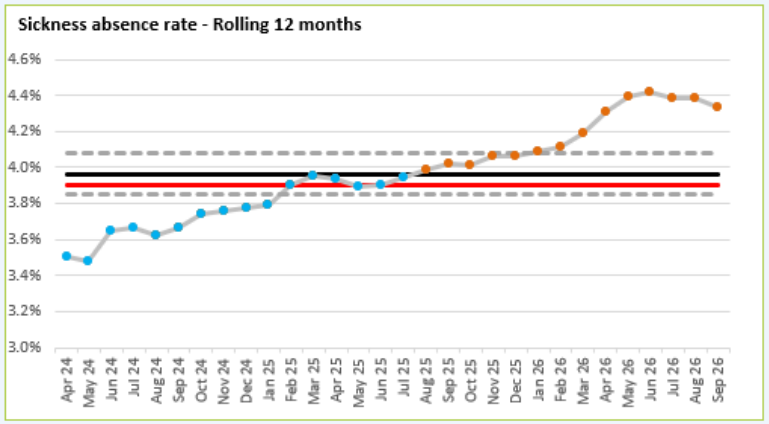












KSO3 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Trust vacancy rate (excluding bank and agency)	M6 shows staff in post WTE (substantive staff) at 1067.75 (against a submitted plan of 1063.92 WTE) which is a variance of 3.83 WTE above plan. Vacancies excluding bank and agency usage have increased slightly from 0.29% to 0.99%. This increase is due to an increase in leavers in September. This remains below our target of 8%.
Average Time to Hire - Days	Slight variation in M6 to 29.57 days (from 27.57 days). Three vacancies were Medical and Dental 'future hires' with start dates at least 6 months from offer date. Three other significant delays were for Day Surgery due to requirments of Occupational Health clearances (102 days and 101 days).
Sickness Absence Rate - Rolling 12 Months	This measure continues at a current level of marginally above 4% target (4.33%). The highest areas of sickness in M6 continued in Theatres, with an increase seen in Radiography and Canadian Wing. The highest staff groups for sickness continue in admin & clerical (30.9%) and nursing (18.9%). The most common reason for sickness absence are consistently cough, cold and flu, and gastrointestinal problems and headache/migraine alongside other MSK issues. The trajectory shows as improving. The Employee Relations team have regular catch-up meetings with managers across the Trust to provide advice, support and guidance in managing staff absences. Overall, the Trust's rolling 12-month long term sickness is 2.47% and short-term sickness is 1.92%.
Agency Usage In Month (WTE)	Agency usage has increased in M6 from 6.59 WTE to 9.96 WTE. Usage consisted of 8.47 WTE Perioperative Care, 1.49 WTE in Core Clinical & Community Services (CCCS), 1.31 WTE Healthcare Scientist in Sleep, 0.17 WTE Additional Professional & Technical in Pharmacy. Perioperative services was in Day Surgery (Nursing 1.93WTE), Recovery (Allied Health Professional (AHP) & Nursing & Midwifery Council (NMC) 1.6WTE), and 4.95 WTE in Theatres (AHP & Nursing). Highest reasons was vacancy, sickness and additional activity/clinic .
Bank Usage In Month (WTE)	Bank usage has decreased from 72.49 WTE in M5 to 66.39 WTE in M6. Decreases are in most directorates across the trust. Perioperative Services have the highest usage at 23.03 WTE followed by Core Clinical & Community Services 13.83WTE and Plastic and Burns with 12.15 WTE. Admin and Clerical , Nursing & Midwifery and Additional Clinical Services staff groups had the highest usage (19.93WTE, 17.21 WTE, 11.23 WTE). Within Perioperative Services , Theatres have the greatest share of bank usage (42%), predominantly due to sickness and additional activity.
Grievances raised	0 grievance raised in M6
% Job plans complete	5 job plans were signed off in September 2026 with 9 awaiting consultant sign off, 1 awaiting sign off by manager, and 6 pending second sign off. The Trust has dropped slightly to 80% of job plans completely signed off. Job plans are normally reviewed Oct-Dec as part of forward planning for the following year and, keeping with national direction, this position will improve through Q3/Q4.
Turnover rate	Turnover has increased from 11.45% in M5 to 11.78% in M6. The Trust's highest turnover rates for M6 are within Corporate. For operational triumvirate's Core Clinical & Community Services (13.65%) has the highest turnover, followed by Plastics & Burns (12.4%).
Statutory and mandatory training	M6 has seen an increase in mandatory and statutory training (MAST) compliance from 90.8% in M5 to 91.4% in M6, with clinical staff completing the new board reportable competency (Safeguarding Adults L1, in addition to L2). Conflict Resolution and Information Governance training are the focus for improvement.
Appraisal rate	There is ongoing work to achieve 90% appraisal completion, with focus on managers where their departments have low compliance. M6 saw a decrease from 86.3% in M5 to 84.6%. The number of appraisals outstanding >3 months slightly increased from 52 in M5 to 54 in M6, with focused work with senior managers in areas where rates of completion are low.

KSO4

To deliver sustainable services

Ambition

That we are cost effective, deliver best value, are committed to our role to support a sustainable environment and the key role of digital in our future pathways and delivery model.

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

Queen Victoria Hospital
NHS Foundation Trust

2026/27 Annual Objectives

1. Maintain financial sustainability, reduction of corporate costs and delivery of £7.5m Better Value Programme
2. Delivery of key estates infrastructure projects and improving estates resilience and backlog maintenance (Major Project)
3. Digital transformation to support Trust and system priority objectives, including Patient Administration System (PAS) (Major Project)
4. Transform diagnostic pathways using Community Diagnostic Centre (CDC) for neighbourhood care (Major Project)

2026/27 Annual goals

1. Successful installation of Altera PAS by November 2026
2. Delivery of the 2026/27 breakeven position
3. Delivery of key Infrastructure projects (CDC – September 2026, MRI – March 2027, RI&E – March 2027)
4. Successful delivery of Sussex Pathology Network Programme (SPN)

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Summary Financial Position

For the Month of September, the Trust reported a Year to Date (YTD) Income and Expenditure surplus of £0.1m, which was in line with plan and a cash position of £12.1m. The position includes £1.1m of non-recurrent benefits of which £0.3m related to M6. The Trust continues to report a forecast breakeven position at Year End with work continuing on delivery of the better value programme and its recovery plan.

Key drivers of position include:

- **Commissioner income** is ahead of plan YTD **(**£0.5m**)** driven by £0.3m ICB/NHSE income mainly due to an increase in the year to date (YTD) depreciation charge (£0.3m) which is funded through ICB income and £0.3m other patient activity income. Underperformance in plastics day cases and the community diagnostics centre is being mostly covered by over-performance in sleep outpatient procedures and devices. Other Patient activity income is favourable to plan mainly due to funding received to deliver additional weekend lists and other mainly one-off items within overseas and Non-Contract Activity (NCA) income. **Other income** is behind plan YTD (£0.1m) mainly driven by underperformance in car parking income and other directorate income.
- **Pay:** Overspent in month by £0.3m and £1.3m YTD mainly driven by slippage on pay better value schemes offset in non-pay. . Pay was in line with YTD in M6 with a small reduction in temporary staffing compared to the higher levels seen in M4 and M5.
- **Non-pay including Non-operational Expenditure**: £0.1m favourable to plan in month and £0.8m favourable for the YTD. The in-month position includes a 0.3m depreciation increase and non-recurrent benefits (£0.3m). The YTD position is driven by reduced spend across clinical supplies, other non-pay and bank interest income and non-recurrent benefits.

Better Value Programme (BVP)

The Trust is reporting full delivery of the M6 efficiency programme, with the core programme contributing to 79% of the reported delivery. The Trust is forecasting a shortfall of £1.0m which is a £0.2m improvement from the previous month. The financial recovery plan is expected to deliver the required improvement to materially close the gap. The latest Model Hospital year-on-year productivity metric for June is 5.3% (6% average for Q1), which is materially higher than it has been over the previous 6 months (1.62%).

Key Estates Infrastructure Projects

- A tender pack for the repair of Main Theatres roof has been issued to the Trust for approval prior to release.
- Ongoing programmes of work are underway relating to fire compliance.
- The design team has now met with the MRI and Jubilee Building task and finish group to answer queries and develop plans to work towards stage 1 completion of the MRI building works.
- The project to refurbish a room for Cone Beam Computer Tomography (CBCT) has been awarded and the pre-start meeting has taken place. Works are due to commence before the end of October.
- The waste compound project is commencing in October and will create a waste compound extension and a refurbished parking area at the rear of the site.
- The replacement of the car park ticket machines in the main car park is being scheduled following a comprehensive procurement exercise, the contract is currently under consideration.
- The main theatre dampers are currently being surveyed by specialists to enable a tender package to be put together.
- The Canadian Wing roof repair will commence at the beginning of November, for completion by the end of November, weather conditions dependant.
- An initial meeting has been held and design plans approved for the doors to be installed at the Main Entrance. A pre-start meeting will be arranged following the submission of a quotation for the enabling works required.
- Quotes for the asbestos removal from the mains water service tunnel have been reviewed and the contract is due to be issued,

Key Transformation Projects (digital, Sussex Pathology Network, CDC)

The East Grinstead CDC was handed over on 20th October 2026. The site is being prepared for opening on 9th November 2026. The Digital Transformation Programme continues to progress; however, it remains under active management with key risks in Patient Administration System (PAS) readiness, Radiology Information System (RIS) procurement, Sussex Pathology Network delivery and programme workforce/funding planning are ongoing.

Ross Dunworth
Interim Chief Finance Officer

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Metric	Latest Month	Target	Variation	Assurance	Actual	Actual Previous Month	Mean	LCL	UCL	Summary
Breakeven YTD	Sep-26	£0.13m			£0.07m	£0.06m	-0.28	-0.93	0.38	Common cause - no signficant change
Cash at Bank YTD	Sep-26	£9.20m			£12.10m	£13.00m	10.15	4.05	16.26	Common cause - no signficant change
Capital Spend YTD	Sep-26	£3.58m	H		£5.40m	£4.60m	4.61	-3.60	12.82	Special Cause - improving variation
Efficiencies YTD	Sep-26	£3.50m	H		£3.50m	£2.85m	3.59	0.40	6.78	Special Cause - improving variation
YTD BPPC (NHS & Non NHS) - volume	Sep-26	95.0%		F	85.5%	82.5%	0.77	0.65	0.89	Common cause - no signficant change
YTD BPPC (NHS & Non NHS) - value	Sep-26	95.0%		F	91.7%	89.3%	89.8%	85.8%	93.7%	Common cause - no signficant change
Agency spend 30% reduction on 25/26	Sep-26	£0.26m			£0.26m	£0.22m	0.16	0.05	0.27	Common cause - no signficant change
In month agency staff spend as % total staff spend	Sep-26	2%	L	P	0.71%	0.42%	0.90%	0.33%	1.47%	Special Cause - improving variation
Bank spend 10% reduction on 25/26	Sep-26	£1.50m	H		£1.62m	£1.38m	0.98	0.25	1.71	Special Cause - improving variation
In month Total Pay cost per Worked WTE	Sep-26		H		£5,830.58	£5,890.81	5733.08	5527.79	5938.38	Special Cause - concerning variation
Subject Access Requests - Total Received	Sep-26		H		117	95	91.05	57.40	124.70	Special Cause - concerning variation
Subject Access Requests - % Closed within 30 calendar days	Aug-26	100%	H		100.0%	100.0%	95.9%	83.4%	108.3%	Special Cause - improving variation
Freedom of Information requests – Total Received	Sep-26				41	31	50.79	16.01	85.56	Common cause - no signficant change
Freedom of Information requests – % Closed within 20 working days	Aug-26	80%			70.97%	65.15%	67.1%	44.4%	89.8%	Common cause - no signficant change

KSO4 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Capital

	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
IT	33	-7	40	99	9	90	300	200	100
Medical Equipment	125	0	125	250	0	250	500	100	400
Estates Maintainance	64	19	45	381	161	220	762	378	384
Sussex Pathology Network	52	15	37	312	166	146	620	620	0
EPR	111	125	(14)	333	412	(79)	1,000	1,200	(200)
CDC	0	665	(665)	1000	4604	(3,604)	1,000	5,443	(4,443)
Other Capital	400	8	392	1200	40	1,160	3,603	-	3,603
Total	785	825	(40)	3575	5392	(1,817)	7,785	7,941	(156)

Income and Expenditure

	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income									
Patient Activity Income	9,760	9,957	197	58,259	58,758	499	115,985	116,617	632
Other Operating Income	425	409	(16)	2,698	2,633	(65)	5,241	4,975	(266)
Total Income	10,185	10,366	181	60,957	61,391	434	121,226	121,592	366
Pay									
Substantive	(6,093)	(6,350)	(257)	(36,859)	(38,029)	(1,170)	(73,443)	(75,378)	(1,935)
Bank	(242)	(248)	(6)	(1,529)	(1,624)	(95)	(2,992)	(2,906)	86
Agency	(44)	(48)	(4)	(264)	(264)	-	(542)	(418)	124
Total Pay	(6,379)	(6,646)	(267)	(38,652)	(39,917)	(1,265)	(76,977)	(78,702)	(1,725)
Total Non-Pay	(2,891)	(2,576)	315	(17,522)	(16,537)	985	(34,818)	(33,035)	1,783
Total Non Operational Expenditure	(796)	(1,023)	(227)	(4,772)	(4,923)	(151)	(9,548)	(9,972)	(424)
Total Expenditure	(10,066)	(10,245)	(179)	(60,946)	(61,377)	(431)	(121,343)	(121,709)	(366)
Surplus/(Deficit)	119	121	2	11	14	3	(117)	(117)	0
Technical Adjustments	10	8	(2)	60	58	(2)	118	118	0
Adjusted Surplus / (Deficit)	129	129	-	71	72	1	1	1	0

Efficiency

	In Month £'000			Year to Date £'000			Forecast Outturn £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Pay - Establishment Reviews	270	121	(150)	1,339	1,016	(323)	2,959	2,785	(174)
Pay - Corporate Service and Digital Transformation	107	85	(22)	583	444	(139)	1,200	1,064	(136)
Pay - Bank	13	8	(5)	71	48	(23)	150	127	(23)
Pay - Agency	2	-	(2)	11	-	(11)	25	14	(11)
Pay - Other	38	-	(38)	208	-	(208)	431	-	(431)
Non-Pay - Procurement	110	112	2	633	486	(147)	1,343	1,155	(188)
Non-Pay - Other	43	298	255	246	1,278	1,032	523	1,639	1,116
Non-Pay Corporate Service and Digital Transformation	52	22	(30)	303	120	(183)	642	475	(167)
Income - Non-patient care	18	8	(10)	108	114	6	204	219	15
Income - Other	1	1	0	6	3	(3)	15	14	(1)
Total	654	654	0	3,508	3,508	0	7,492	7,492	0



	Annual Target	Forecast Outturn
Income & Expenditure	£0.0m	£0.0m
Cash at bank	£5.6m	£5.6m
Capital Spend	£7.8m	£7.8m
Efficiencies	£7.49m	£7.49m
BPPC (NHS & Non-NHS)		
Volume	95.0%	91.9%
Value	95.0%	93.6%

Trust Better Value Programme

Queen Victoria Hospital
NHS Foundation Trust

Better Value Programme:

	Annual Plan £000				M06 Year-To-Date £000		
Theme	NHSE Plan	Latest Estimate	Indicative Forecast	Variance	NHSE Plan	Actual	Variance
Clinical Productivity & Efficiency	£3,479	£3,552	£2,862	(£690)	£1,585	£1,446	(£139)
Corporate and Partnership	£1,250	£1,054	£1,017	(£38)	£607	£443	(£164)
Grip and Control	£680	£747	£496	(£252)	£318	£174	(£144)
Digital Transformation	£380	£250	£213	(£38)	£177	£49	(£128)
Commercial and other income	£269	£398	£304	(£94)	£138	£243	£105
Admin Review	£500	£275	£0	(£275)	£240	£0	(£240)
Temporary Staffing	£175	£97	£97	£0	£82	£48	(£34)
Planned Non-Recurrent items	£759	£759	£759	£0	£361	£361	£0
Other Mitigating Items		£359	£743	£384		£743	£743
Grand Total	**£7,492**	**£7,492**	**£6,489**	**(£1,003)**	**£3,508**	**£3,508**	**(£0)**
Financial Recovery Plan			£800	£800			
Further Mitigations			£203	£203			
Totals	**£7,492**	**£7,492**	**£7,492**	**£0**			

Better Value Programme (BVP):
As the Trust met its financial plan for month 6, it is reporting full delivery of the efficiency programme. Year-to-date delivery from the agreed efficiency schemes makes up 79% of the total reported delivery, this is a further reduction from the prior month (81%), reflecting the reliance on other mitigating items to support the efficiency programme. The forecast shortfall of £1.0m is £0.2m better than the previous month due to the delivery of the M6 position.

Productivity indicators:
The Model Hospital productivity data has been updated and data for April to June has been published and whilst there have been changes to the methodology, largely impacting the valuation of activity, the encouraging metric for QVH is the real terms cost reduction. Over the first quarter, QVH has seen an average real terms cost reduction of 1.7%, which, coupled with an average increase in cost weighted activity of 4.2%, has led to a year-on-year productivity improvement of 6% for Q1 and 5.3% for June.
The proportion of OPA that are either First attendances or OPROCs continues to be above target and contributing to the strong YTD delivery of the Outpatients (OP) Transformation Programme and clinical productivity BVP.

Key Productivity Indicators:

Source	Metric	Latest Month	Latest Month	Target	Distance from Target	5 mth Trendline
Model Hospital	Productivity Growth (YTD vs Prior Year)	Jun-26	5.30%	3.00%	2.30%	
Model Hospital	Workforce Productivity Growth (YTD vs Prior Year)	Jun-26	3.80%	3.00%	0.80%	
OP Dashboard	Proportion of OPA that are First or OPROC	Sep-26	49.90%	46.00%	3.90%	

The headline productivity metrics are taken from the Model Hospital and are reported several months in arrears. Although there are some limitations with the underlying measurement, these metrics give a broad indicator of the productivity trajectory, by comparing the year-on-year change in the value of outputs (clinical activity) with the resources consumed (cost).

Outpatient Attendance (OPA)
Outpatient Procedures (OPROC)

KSO4 AREAS OF FOCUS

Queen Victoria Hospital
NHS Foundation Trust

Area	Summary, impact and actions
Breakeven YTD	• The Trust reported a surplus position of £0.1m YTD for M6, which was on plan. This includes £1.1m of non-recurrent benefits. Income is £0.5m ahead of plan across ICB/NHSE and other patient care income. **Pay** is overspent by £1.3m YTD, mainly due to under delivery of better value schemes and is mostly offset by non-pay underspends. **Non-pay including Non-operational Expenditure** was £0.8m favourable to plan across clinical supplies, other non-pay and bank interest income. The main risks to breakeven will be delivery of the recovery plan actions required to deliver the annual plan.
Cash at Bank YTD	• The Trust's cash balance at M6 was £12.1m, which continues to be supported by capital cash earmarked for completion of the Community Diagnostic Centre (CDC), EPR (PAS) and the estate safety funding.
Capital Spend YTD	• Capital expenditure at Month 6 totals £5.4m, which is above the planned £3.6m for the period. This variance reflects the phasing of the plan, with actual expenditure being incurred in line with the CDC build and EPR progress. • The total annual capital allocation is £8.0m. Of this, £5.6m is expected to be spent on the CDC and £1.2m on (Electronic Patient Record (EPR), with the remaining balance allocated across Estates, IT, and Sussex Pathology Network (SPN). The capital programme is awaiting the outcome of national bids; the Trust plan is reliant on some of these being awarded.
Efficiencies (Cost Improvement Plans) YTD	• The Trust is reporting full delivery of the M6 efficiency programme, with the core programme contributing to 79% of the reported delivery. The Trust is forecasting a shortfall of £1.0m which is a £0.2m improvement from the previous month. The financial recovery plan is expected to deliver the required improvement to materially close the gap. The latest Model Hospital year-on-year productivity metric for June is 5.3% (6% average for Q1), which is materially higher than it has been over the previous 6 months (1.62%).
Better Payment Practice Code (BPPC) (NHS & Non-NHS) Volumes	• 85.5%
BPPC (NHS & Non-NHS) Values	• 91.7%
Agency spend 30% less than 25/26	• On plan metric for YTD (£0.3m). A slight increase in M6 due to increased usage in theatres nursing linked to activity and sickness
Agency Spend Less than 2% of Total Pay Bill	• Ahead of plan (0.65 % YTD) and slightly increase in M6 as above
Bank spend reduction of 10% of Total Pay Bill	• Slightly behind YTD plan by £0.1m mainly driven by higher spend associated with funded additional lists. Plans are being reviewed to reduce bank spend in future months across all areas
Pay Spend	• £1.3m adverse to the YTD plan mainly due to non-delivery of pay Better Value schemes. Pay was in line with YTD trend for M6. The Trust is looking at reducing the pay run rate to support the Trusts delivery of the financial plan including developing and implementing a recovery plan.
Non-Pay Spend including non-operational expenditure	• £0.8m favourable to plan due to lower than planned spend in clinical supplies, other non-pay and interest income above plan. The position is supported by non-recurrent benefits YTD. The Trust is working to maintain the current run-rate and identify ways of reducing the spend through areas such as transport, postage and clinical procurement savings.

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Estates Infrastructure (incl. resilience/backlog maintenance, MRI relocation, Research, Education and Innovation Centre)

Exec Lead: CPO/CMO
Lead: Director of Estates/PMO

Reporting Month: October 26

Overall Status: Amber

Fire Doors:
- A tender pack has been compiled by a specialist contractor and has been reviewed by the estates and Fire team. This will include the following areas: Critical Care Unit (CCU), Head and Neck and Burns.

Fire alarm:
- Additional surveys have been carried out and will be returned before the end of October. The team will then evaluate before award.

Kitchen Boiler:
- Commissioning currently progressing with some alterations being worked through.

Theatre Dampers:
- Survey by specialist is underway. The findings will enable the build of a specification for tender.

MRI:
- The specialist design team have linked with the MRI supplier and are actively carrying out the required surveys. The design team have attended the task and finish group to address questions. A draft programme has been provided, awaiting details for RIBA stage 1.

Research Education and Innovation Centre:
- Terms of Reference (TORs) are complete and fortnightly Task and Finish Group meetings are in place to scope opportunity. Design consultants are being engaged to consider facility options.

Theatres Roof Repair:
- A draft tender package has been returned and is now with the estates and procurement team for consideration prior to release.

Waste compound extension:
- Works to the waste compound extension are due to commence at the end of October and will be completed by the end of November. Completion will see the movement to the new waste storage area and additional parking spaces being available.

Canadian Wing Roof Repair
- Works to the Canadian Wing roof will commence at the beginning of November, weather dependant it is anticipated that completion will be by the end of November.

Service Tunnel Asbestos Removal
- The bidders' returns have been evaluated and will now go through the procurement process for award.

Cone Beam Computed Tomography (CBCT) Room Refurbishment
- A comprehensive tender exercise has been carried out by the procurement team and the project awarded. The pre-start meeting has been held with works due to commence before the end of October.

Milestone		Start Date	Expected Completion Date	Commentary
MRI equipment purchased		15th May 2026	31st September 2026	One equipment manufacturer has been shortlisted as the preferred provider. The contract will shortly be awarded after agreement through the appropriate approvals process.

KSO4 PROJECT REPORT

NHS
Queen Victoria Hospital

Digital Transformation Programme	Exec Lead: CMO Lead: PMO/Head of EPR	Reporting Month: October 26	Overall Status: Amber

The Digital Transformation Programme remains at Amber status and is under active management. 12 workstreams are currently rated either red or amber. Further progression of integrated order communications, eConsent and wider outpatient transformation have been descoped until PAS completion. Executive focus remains on Patient Administration System (PAS) replacement with a delay to the planned go live end November 2026. Replanning is underway with an expected go live of Q2 2027. Radiology Information System (RIS) procurement and delivery of the Sussex Pathology Network (SPN) programme also remain significant risks. The overall programme position reflects a broad and active portfolio, with positive progress having being made in electronic prescribing and medicines administration (ePMA), Patients Know Best (PKB), Artificial Intelligence (AI) and GP digital communications.

There has been tangible movement across several amber workstreams, including ePMA. 16/17-year-old prescriptions are now live (with all of paediatrics scheduled to go live in November), Electronic Discharge Notification (EDN) delivery is in advanced planning but has incurred some delays due to report complexity, Patient Know Best (PKB)/patient communication activity (switching off of paper records for patients registered on PKB and Radiology appointment letters and TCI letters also now digitised) has now taken place, AI governance development (Ambient Voice Technology (AVT) pilot being planned for November) and hardware deployment have now moved to business as usual. Delivery remains dependent on specialist capacity, PAS system readiness, operational capacity, Business Intelligence (BI) capacity / reporting availability and timely progression of planned milestones. Several workstreams also share common dependencies meaning that delays in one area such as resolution of identified issues in the platform, may affect wider programme delivery. Key risks continue to relate to the PAS go live even with a deferred go live particularly with product stability, operational and digital capacity. NHSE assurance review has taken place, and the Trust are waiting for a formal report to be released.

Workforce continuity is also a material concern, with programme staff funding ending in December 2026. Continued executive oversight will therefore be required to maintain delivery grip, support prioritisation of constrained specialist resources and manage the cumulative impact of these risks across the digital transformation portfolio. Applications for funding have been submitted to both Frontline Productivity and Wayfinding programmes with EPR admin optimisation and Cyber approved to date. Matched funding was used to secure Tiger Team resources to support PAS. Frontline Productivity Investment Agreements to be completed for any successful bids.

Milestone	Start Date	Expected Completion Date	Commentary
PAS Go Live	4th January 2026	Q2 2027	Status is Amber with the go live date being deferred until Q2 2027 with the plan and resource plan being re-baselined. System unavailability has impacted key workstreams including build, data migration, integration and Business Intelligence (BI)/Reporting. Operational and digital capacity are a significant challenge/risk to project delivery.

Date Raised	Risk Description	Mitigating Actions
April 2026	Funding constraints for programme delivery. There is no funding currently available beyond December 26 for several members of the programme team.	Applications for funding have been submitted to both Frontline Productivity and Wayfinding programmes with EPR admin optimisation and Cyber approved to date. Trust has been successful with funding via FP programme and have also bid for any NHSE underspend to fund team.
April 2026	Unavailability of the new PAS system has impacted key workstreams including build, data migration, integration and BI/Reporting.	Executive escalation has taken place with Altera. Altera have committed to providing a stable system by November.
July 2026	Operational and digital capacity to perform key project activities, such as, clinic builds, system and data migration testing as well as release for training prior to go live	Programme team working with the senior operations team to articulate exactly what skillsets are required and for how long. Formal request to bank has been approved to fund additional work by operations teams. Discussions underway with Altera to bridge resource gaps. Tiger teams secured for Training function.

KSO4 PROJECT REPORT

Queen Victoria Hospital
NHS Foundation Trust

Community Diagnostics Centre (CDC)	**Exec Lead: CMO** **Lead: PMO**	**Reporting Month: October 26**	**Overall Status: Red**

Programme for the delivery of a CDC within the East Grinstead QVH site.

Progress has been made within the following areas:

1. Takeover delayed from 16/10/26 to 20/10/26 due to contractor not completing the scope.
2. Building control certificates requested 16/10/26. 10-day return time predicted, certificates received 3/11/26,
3. Opening date not impacted: 9th November in the afternoon.
4. Activity against plan for CDC activity in August 2026 was 91% and income against plan was 94%, performance is actively monitored and new pathways are opening up.

Key areas for focus are completing the construction of the new CDC building and optimising current CDC activity in East Grinstead.

Milestone	Start Date	Expected Completion Date	Commentary
Operational opening of the centre	01/09/2026	09/11/2026	Revised transition plan drawn up for move of services.
Construction completion on East Grinstead site.	01/09/2025	20/10/2026	5-week delay reported by Contractor and new programme issued with a 4-week delay on operational opening through reduction of the set up period between handover and opening.

Date Raised	Risk Description	Mitigating Actions
04/04/2025	Actual CDC activity vs plan.	Continued remedial actions being taken to bring back to plan.
01/05/2026	Project may go over budget because contingency has been used.	Meeting held between Project Manager (PM) and Finance Team o look at budget vs forecast costs.
25/08/26	Further CDC Delays - commissioning	Weekly meeting/walkaround with Contractor to identify progress against plan. PA has appointed Mechanical, Electrical and Plumbing (MEP) technical advisor to witness commissioning.

KSO4 PROJECT REPORT

Queen Victoria Hospital NHS Foundation Trust

Sussex Pathology Network (SPN)

Exec Lead: QVH MD
Lead: PMO

Reporting Month: Month 6- September

Overall Status: R / A / G
Amber

Summary: There has been a full re-evaluation of the programme across Sussex, reflecting the complexity and scale of the programme. Timescales have been revised across the system with QVH LIMS/ICE due to go live in mid 2027.

LIMS/Order Comms (ICE) – Programme management changes in July has seen ownership of the delivery placed with the SPN Trusts. Contract Change Notice (CCN) extensions for LIMS and OCS have now been signed. Revised go live dates have been set with the earliest go live set for 16th August 2027 and the latest of the three go lives to be completed by 25th January 2028. The intention is for all SPN go lives to be completed by the end of 2027/28. The programme plan has been rebaselined with Clinisys. The programme is moving into the testing stage, after completion of its Stage Gateway review, for both LIMS and OCS.
Digital Histopathology (DHP) - A limited go-live status has been achieved but further validation will continue throughout September and into early October to ensure that processes continue to meet all necessary standards for management of patient images and clinical reporting. Work continues to identify all requirements for PACS-based reporting integration with the new LIMS environment in 2027
Digital Infrastructure - Awaiting confirmation from Clinisys in order to progress with systems integration testing (SIT). All Data Manager connections are now in place. QVH to UHSx connections for the ADT (a conceptual data structure model) and devices have been confirmed for point of care testing (PoCT)
Managed Service Contract (MSC) – Final dialogue sessions will be completed next month. Discussions taking place with NHSE regarding requirements of the Financial Business Case (FBC) and associated governance timeline with an aim to reduce both (contract award predicted - end September 2027). Target for final round documentation issue will be November 2026.
Network Formation and Laboratory Operating Model (LOM) - The Network Formation work continues with support from Execs from each member organisation within SPN who will attend a workshop with the legal team in November. LOM outline business case (OBC) is progressing with the first draft due in Dec in line with predicted milestones. A future state LOM expected to take effect from 2030/31.

Milestone	Start Date		Expected Completion Date	Commentary
MSC – Completion of revised bidder packs ready for distribution	August 2026		Nov 2026	Follows completion of final dialogue sessions at the end of October 2026
LIMS/OCS - Completion of review of all outstanding Change Control Notices (CCNs) by Clinisys	April 2026		Sept 2026	A re-baselined plan between Clinisys and SPN has been submitted for review and sign off
DHP – Completion of end-to-end validation	July 2026		Oct 2026	Full clinical and operational sign off will have been achieved following a successful validation process
LOM – Continuation of OBC development	June 2026		Nov 2026	Distribution of the first draft will be December following the Nov review by key stakeholders

Date Raised	Risk Description	Mitigating Actions
April 2026	Lack of confirmed external NHSE funding to support programme costs for FY26/27	Trusts have agreed to proceed at risk. Partial funding has been offered to support DHP based projects but not LIMS and Order Comms.
April 2026	LIMS/OCS go-live window remains dependent on availability of resources and adherance to strict achievement of key milestones	SPN & Clinisys have agreed content for two Change Control Notices (CCNs) and revised go-live dates have been set

KSO5

To collaborate with others

Ambition

Core to our future as part of a system, as a leader delivering to multiple Systems and reflecting our ambition in regard to anchor, NHS, academic & commercial activities for the future.

Board Assurance Framework

01 Patient services
02 Workforce strategy
03 Physical infrastructure
04 Long term sustainability
06 Financial sustainability
07 Information assets
08 Partner organisations

2026/27 Annual Objectives

1. Strategic Partnership Transition and Implementation (Major Project)
2. Delivery of external and internal engagement plan
3. Support system transformation through Provider Collaborative

2026/27 Annual goals

1. Delivery of key partnership transition milestones
2. Implementation of the Trust engagement plan
3. To support the delivery of Sussex and Surrey Provider Collaborative priority plans including single point of access (SPOA)

KSO5 EXECUTIVE SUMMARY

Queen Victoria Hospital
NHS Foundation Trust

Strategic partnership (implementation and transition)

- With QVH now formally part of the Group partnership with Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH) and Royal Surrey NHS Foundation Trust (RSFT), the leadership arrangements are fully established. We are delighted to welcome Louise Stead as Group Chief Executive Officer and Joss Bigmore as Chair of QVH. Together with Tamara Everington, Managing Director, and Angela McNab, Chair and Non-Executive Director, our focus remains on delivering the benefits of closer collaboration while strengthening QVH's specialist services and preserving the expertise for which the Trust is known.
- As we progress into the next phase of the Group partnership, work is underway to shape our focus for the next three to six months. A number of key priorities have been identified, and further detail on these will be shared over the coming weeks.

Engagement (internal/ external)

- Work is progressing on the Trust's Engagement and Communication Strategy that sets out the direction for QVH over the next three years, with a focused set of engagement priorities identified over the next six months, aligning to the Trusts Key Strategic Objectives (KSOs). The proposal is to move beyond measuring engagement activity alone to understand in more detail whether our engagement is supporting QVH to achieve its organisational priorities. This includes our staff, volunteers, patients and our wider stakeholders to strengthen connection, whilst gathering the feedback and undertaking any learning, using a Continuous Improvement approach.

- From a Group perspective the Communications and Engagement teams continue to work collaboratively to share news across each organisation to share and understand out initial priorities over the next 3-6 months.

Provider Collaboratives (Acute and neighbourhood, including Single Point of Access (SPoA))

- The Provider Led Single Point of Access (SPoA) project has now been successfully completed, with 10 specialties transitioned to SPoA model through eRS.
- Building on this progress, the focus for the Surrey and Sussex ICB has shifted towards the development and implementation of Sussex SPoA for elective referrals and the aim of developing and implementing Sussex-wide SPoA starting with a proof-of-concept system-wide SPoA. The development of a SPoA is a central component of the Sussex system's response to the national NHS 10-Year Plan and to local pressures on elective services. Its aim is to ensure patients are directed and managed within the part of the system that best meets their clinical needs, while also increasing patient choice and supporting improvements in overall waiting times.

Kathy Brasier
Acting Chief Strategy Officer

Interpretation of Summary Icons for Statistical Process Charts

Queen Victoria Hospital NHS Foundation Trust

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	**Excellent** — **Celebrate and Learn** • This metric is improving • Your aim is high numbers, and you have some • You are consistently achieving the target because the current range of performance is above the target	**Good** — **Celebrate and Learn** • This metric is improving • Your aim is high numbers, and you have some • Your target lies within the process limits so we know that the target may or may not be achieved	**Concerning** — **Celebrate but Take Action** • This metric is improving • Your aim is high numbers, and you have some • HOWEVER, your target lies above the current process limits so we know that the target may or may not be achieved without change	**Excellent** — **Celebrate** • This metric is improving • Your aim is high numbers, and you have some • There is currently no target set for this metric
L	**Excellent** — **Celebrate and Learn** • This metric is improving • Your aim is low numbers, and you have some • You are consistently achieving the target because the current range of performance is below the target	**Good** — **Celebrate and Learn** • This metric is improving • Your aim is low numbers, and you have some • Your target lies within the process limits so we know that the target may or may not be achieved	**Concerning** — **Celebrate but Take Action** • This metric is improving • Your aim is low numbers, and you have some • HOWEVER, your target lies below the current process limits so we know that the target may or may not be achieved without change	**Excellent** — **Celebrate** • This metric is improving • Your aim is low numbers, and you have some • There is currently no target set for this metric
○	**Good** — **Celebrate and Understand** • This metric is currently not changing significantly • It shows the level of natural variation you can expect to see • HOWEVER, you are consistently achieving the target because the current range of performance exceeds the target	**Average** — **Investigate and Understand** • This metric is currently not changing significantly • It shows the level of natural variation you can expect to see • Your target lies within the process limits so we know that the target may or may not be achieved	**Concerning** — **Investigate and Take Action** • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • Your target lies below the current process limits so we know that the target will not be achieved without change	**Average** — **Understand** • This metric is currently not changing significantly • It shows the level of natural variation you can expect to see • There is currently no target set for this metric
H	**Concerning** — **Investigate and Understand** • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • HOWEVER, you are consistently achieving the target because the current range of performance is below the target	**Concerning** — **Investigate and Take Action** • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • Your target lies within the process limits so we know that the target may or may not be achieved	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating • Your aim is low numbers, and you have some high numbers • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • There is currently no target set for this metric
L	**Concerning** — **Investigate and Understand** • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • HOWEVER, you are consistently achieving the target because the current range of performance is above the target	**Concerning** — **Investigate and Take Action** • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • Your target lies within the process limits so we know that the target may or may not be achieved	**Very Concerning** — **Investigate and Take Action** • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — **Investigate** • This metric is deteriorating • Your aim is high numbers, and you have some low numbers • There is currently no target set for this metric

SPC Chart Key:

- Mean
- Target
- Process limits
- Special cause - concern
- Special cause - improvement

GLOSSARY

Queen Victoria Hospital
NHS Foundation Trust

Abbreviation	Definition
AfC	Agenda for Change
AHP	Allied Health Professionals
BAF	Board Assurance Framework
BLS	Basic Life Support
BPPC	Better Practice Payment Code
BU	Business Unit
CD	Clinical Director
CDC	Community Diagnistic Centre
CDEL	Capital Departmental Expenditure Limit
CDI	Clostridium difficile infection
CEO	Chief Excutive Officer
CFO	Chief Financial Officer
CI	Continuous Improvement
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COO	Chief Operating Officer
COTD	Cancellations on the Day
CPO	Chief People Officer
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRL	Capital resource Limit
CSO	Chief Strategy Officer
DATIX	Reporting system for reporting clinical incidents
DM01	Diagnostic waiting times and activity
DNA	Did Not Attend
DSU	Day Surgery Unit
DTA	Decision to Admit
EDI	Equality, Diversity and Inclusion
ENT	Ear Nose and Throat
EPR	Electronic Patient Record
ER	Employee Relations
ERF	Elective Recovery Fund

Abbreviation	Definition
ESR	Electronic Staff Record
F2SU	Freedom to Speak Up
FBC	Full Business Case
FDS	Faster Diagnosis Standard
FFT	Friends and Family Test
FPT	Full Patient Transfers
GA	General Anaesthetic
GIRFT	Getting It Right First Time
GM	General Manager
H&N	Head and Neck
HoD	Head of Department
ICB	Integrated Care Board
ICE	Integrated Clinical Environment
ICS	Integrated Care System
IP	Inpatients
IPACT	Infection Prevention and Control Team
IS	Independent Sector
KPI	Key Performance Indicator
KSO	Key Strategic Objective
LAB	Local Academic Board
LAU	Local Anaesthetic Unit
LEEP	Leadership through Education for Excellent Patient Care
LFG	Local Faculty Group
LIMS	Laboratory Information Management System
MAST	Mandatory and Statutory Training
MIU	Minor Injuries Unit
MRSA	Methicillin-resistant Staphylococcus Aureus
MSC	Managed Service Contract
MSK	Musculoskeletal
MSSA	Meticillin Sensitive Staphylococcus Aureus
NHSE	NHS England
NICE	National Institute for Health and Care Excellence

Abbreviation	Definition
OBC	Outline Business Case
OD&L	Organisational Development & Learning
OH	Occupational Health
OIP	Outline Implementation Plan
OMFS	Oral and Maxillofacial surgery
OPD	Outpatients Department
OPPROC	Outpatient Procedure
PAS	Patient Administration System
PDC	Public Dividend Capital
PDSA	Plan, Do, Study, Act
PID	Project Initiation Document
PIFU	Patient Initiated Follow Up
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measure
PSIRF	Patient Safety Incident Response Framework
PTL	Patient Tracking List
QNET	Queen Victoria Hospital's intranet
QP	Quality Priority
RTT	Referral to Treatment
SDP	Shared Delivery Plan (NHS Sussex)
SLNB	Sentinel Lymph Node Biopsy
SPC	Statistical Process Control
SPN	Sussex Pathology Network
SSCA	Surrey and Sussex Cancer Alliance
TMJ	Temporomandibular Joint Dysfunction
VPR	Violence Prevention Reduction
VWA	Value Weighted Activity
WRED	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**95-26**		
Report title:	QVH Business planning 2027/28 - initial approach				
Sponsor:	Ross Dunworth, Interim Chief Financial Officer				
Author:	Jonathan Wharton, Deputy Chief Finance Officer				
Appendices:	None				
Executive summary					
Purpose of report:	Summary of the QVH business planning approach for 2027/28 with national assumption				
Summary of key issues	• No new guidance is expected just updates and refreshes on the 2026/27 guidance. So this is to be used for planning until new information is released • An outline on how we will do the high level NHS England submission is included • A timetable is not known but an estimated one is included which goes over internal reviews and the expected first submission in December 2026. • It is expected that Q4 will have regional discussions and two further submissions in February and March 2027. • Expectation that board assurance will be required. • Lessons learned from 2026/27 planning which go over a number of bullet points of how things went in 2026/27 including changes to using run rates. • Planning approach for doing the internal detailed plans. This is expanded from the overall plan with a proposal to submit first draft budgets by December 2026 with Q4 used for further development of budgets, capital and Better Value programme.				
Recommendation:	To Board is asked to note the framework and discuss and feedback on the approach proposed				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	KSO2: *To innovate and improve*	KSO3: *To be an excellent employer*	**KSO4:** ***To deliver sustainable services***	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	KSO4				
Organisational risk register:	Risk nos.: 00000144/148/149/161				
Regulation:	NHS Provider Licence				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Finance & performance committee				
	Date:	02/11/2026	Decision:	Noted	
Next steps:	None				

Queen Victoria Hospital
NHS Foundation Trust

Business Planning Initial Approach 2027/28

V1.0



2026/27 Planning review

2026/27 Review

Queen Victoria Hospital
NHS Foundation Trust

Key areas that need to be reviewed and changed for 2027/28

- Control totals were set on 2025/26 budgets. This made it simple to implemented but meant that budgets had to be adjusted for unidentified CIPs. It also meant that unused budget was returned to areas and did not align to run rates.
- Service investments were identified and kept at a lower level than the previous year but there are still outstanding ones that have not been implemented or final decisions made.
- Investments took longer than expected to finalise and required serval reviews.
- Activity and Income took some time to align and the phasing of both did not match in a way to ensure matching in year.
- Activity plans were stretching to meet NHSE requirements but a method for delivery was not fully identified and included throughout the various returns.
- The workforce WTE aligned with the finance changes but without detailed CIPs estimates were made for the staffing groups that would see changes in staffing levels.
- Update in ESR was delayed due to late sign off of the budgets and therefore transfer of information.
- The Better Value programme was set at quite a high level with little coming out of the directorates and most schemes being cross Trust
- Few budget holders involved in the process as it was managed at senior level.
- Board assurance had to be done at short notice due to finishing the work and the timing of the submission.
- Sign off and budget loads were after the year had started

Business Planning Approach - NHSE Submission

Key points from guidance for plan

Queen Victoria Hospital
NHS Foundation Trust

NHSE plan overall key points

- NHSE have stated that new Guidance wont be released but letters and updates will be released in order to refresh the guidance from last year.
- Guidance released last year covered multiple years and therefore is to be used for 2027/28
- A plan was submitted for 3 years with a 5 year capital submission.
- It is expected that the previous submission will be used as a baseline to set the plan.
- Although not confirmed I would expect them to require a bridge from that plan to the new one which would still expect that **breakeven** and **activity** plans are met.
- Previously a rolling plan was discussed so the new plans would extend by one year or bring both up to 5 years.
- Integrated tools to be used to increase transparency across Finance, Workforce and Activity.
- Capital limits were set last year and are expected to remain unchanged.
- Cap on 2.5% reduction in funding is expected to remain in place.
- Expected Submission dates of December, February and March
- Board assurance sign offs are expected to be required for the 2027/28 submissions.

NHSE planning approach

Queen Victoria Hospital
NHS Foundation Trust

Initial plans for 2027/28

- Forecast position for 2026/27
- Underlying position for 2026/27
- Build Demand and Capacity models
- Agree and apply planning assumptions (inflation, CUF etc)
- Build bridge for 2027/28 plans

Activity, workforce and cost baseline

- Build activity plans
- Build workforce plans to deliver the activity plans
- Build income and expenditure plans to deliver activity plans

Significant Service Changes

- Identification of significant changes to services

Better value programme

- Identify the required Better Value programme value
- Build the Better Value programme

Capital Programme

- Build a capital programme to align to capital funding.

Business Planning Elements - Demand and Capacity modelling

Queen Victoria Hospital NHS Foundation Trust

Demand and Capacity modelling

- Build capacity models (day case, inpatients, non-elective and outpatients)
- Develop plan to align elective and outpatient scheduling with demand and job plans,
- 2027/28 activity plan to incorporate:
  - Adjustments for non-elective seasonality
  - Adjust for recent staffing changes/service developments
  - Plus new service developments and POD changes in 2026/27 & 2027/28
  - Plus agreed growth (demographic and other)
  - Update for changes in tariff
  - Built to deliver the activity targets as per the multi year plans

Service Changes

- Identify any significant service changes including
  - Updates to the CDC delivery following part year operation
  - Service step changes from demand
  - Partnership working

Business Planning Elements – Financial, Workforce & Activity plans

Queen Victoria Hospital NHS Foundation Trust

Pay, Non Pay and income

- Baseline – Use Forecast outturn from M6 YTD to provide base 2027/28 budget
- Inflation increased as per NHS guidance 2027/28
- Reduce baselines to remove non recurrent items included in the M6 YTD spend
- Update for FYE of service developments and cost pressures from 2026/27 where these were already in place.
- Build in reserve for service pressures (adjust as final number identified)
- Apply Better value targets to deliver the required breakeven

Build workforce

- Baseline – Initial budget provided inline with 2026/27 FOT
- Review budgets and ensure WTE aligns with budgets
- Update WTE for 2026/27 Better value adjustments
- FYE of service developments from 2026/27
- Build in agreed service pressures

Activity

- Build activity plans to align to demand and capacity modelling
- Cost up plans
- Apply to the Trust financial budget

Triangulate

- Compare across all three areas to ensure alignment

Approach to Business Planning – Capital

Queen Victoria Hospital
NHS Foundation Trust

Approach to Capital

- Assume allocations already set remain unchanged
- Develop essential capital requirements for 2027/28
  - Development of comprehensive multi-year rolling replacement equipment programme
  - Backlog maintenance plan
  - IM&T/Digital strategy
  - Capital bids
  - MIU refurbishment
- FYE of capital projects 2027/28
- Additional capital allocation split between E&F, Digital and medical equipment
- Apply for any funding opportunities that arise throughout the process

NHSE Plan Sign Off

Queen Victoria Hospital
NHS Foundation Trust

Board review and Sign-off Approach

- Progress to be reviewed at each F&P committee
- Sign off by the Trust Board in December
- Submission of Trust plans in December
- Q4 of 2025/26 discussions with regional NHSE team to finalise
- F&P/Board to be kept up to date and sign off final plan if it changes.
- Expected Board assurance sign off. Agree timing of Board or Exceptional board (depending on timing)

Key Planning Milestones

Queen Victoria Hospital
NHS Foundation Trust

Key Planning Milestones	Date
F&P progress review of plans	02-Nov-2026
Board approval of plan and assurance	Dec 2026
Submission Trust initial plan	Dec 2026
Feedback on plans	Q4
2nd Submission	Feb 2027
Final Submission	Mar 2027

- No dates have been confirmed yet

2027/28 Business Planning submissions from the multi year 2026/27 submissions

Capital Funding - Allocations

Queen Victoria Hospital
NHS Foundation Trust

Capital Programme	Funding Source	2026/27 Plan	2027/28 Plan	2028/29 Plan	2029/30 Plan	2030/31 Plan
IT Hardware	Internally Funded	300	750	1,500	1,500	1,500
Medical Devices & Equipment Replacement Programme	Internally Funded	500	750	1,000	1,000	1,000
Estates Programme	Internally Funded	762	2,484	2,523	2,608	3,563
EPR	Internally Funded	1,000				
East Grinstead CDC	Internally Funded	1,000				
Sussex Pathology Network	Internally Funded	620				
Estaes Safety Funding Programme	PDC - Estates Safety Fund	3,603				
MIU refurbisment	PDC - Elective Recovery		500			
Total		**7,785**	**4,484**	**5,023**	**5,108**	**6,063**

- Total for 2027/28 is £4.5m
- £0.5m for MIU
- The rest to be split as per capital plan updated builds

I&E plans – Submitted 2026/27

Queen Victoria Hospital
NHS Foundation Trust

	2025/26 Outturn	2026/27 Plan	2027/28 Plan	2028/29 Plan	2029/30 Plan	2030/31 Plan
Operating Income from patient care activities	115,453	114,355	115,360	117,033	118,962	120,898
Other operating income	4,226	5,093	5,093	5,093	5,093	5,093
Employee expenses	(76,499)	(75,677)	(76,402)	(77,831)	(79,427)	(81,029)
Operating expenses excluding employee expenses	(41,676)	(41,410)	(41,684)	(41,928)	(42,261)	(42,595)
Operating Surplus/(Deficit)	**1,504**	**2,361**	**2,367**	**2,367**	**2,367**	**2,367**
Finance Costs	(1,778)	(2,478)	(2,485)	(2,485)	(2,485)	(2,485)
Surplus/(Deficit)	**(274)**	**(117)**	**(118)**	**(118)**	**(118)**	**(118)**
Remove capital donations	274	118	118	118	118	118
Adjusted Financial Performance Surplus/(Deficit)	**-**	**1**	**-**	**-**	**-**	**-**
CIP included in the plan	7,460	7,492	4,257	3,523	3,314	3,363
CIP as a percentage of Turnover	6.2%	6.3%	3.5%	2.9%	2.7%	2.7%

- 2026/27 needs updating to the current FOT
- 2027/28 to be updated with current assumptions including expected changes to income and unbundling the block.
- CIP update to deliver the breakeven.
- Expectation of a 5 year submission

Workforce plans – Submitted 2026/27

Queen Victoria Hospital
NHS Foundation Trust

Summary Staff WTE Detail	Establishment Plan 31/03/2027 Year Ending WTE	Establishment Plan 31/03/2028 Month 12 WTE	Establishment Plan 31/03/2029 Month 12 WTE
Total non medical - clinical substantive staff	583.67	577.22	574.92
Total non medical - non-clinical substantive staff	340.12	320.70	304.84
Total medical and dental substantive staff	199.76	201.50	203.24
Total WTE substantive staff	**1123.55**	**1099.42**	**1083.00**
Bank staff WTE	0.00	0.00	0.00
Agency staff WTE	0.00	0.00	0.00
Total staff WTE	**1123.55**	**1099.42**	**1083.00**

- The ending establishment needs updating to represent final staffing levels
- Update the future years
- Expectation of expanding to 5 year plan.

Activity plans – Submitted 2026/27

Queen Victoria Hospital
NHS Foundation Trust

Planning Metric	2027/28 Ask	2027/28 Ask Date Range	2027/28 Specific Target/ Baseline	2027/28 Plan
Percentage of RTT waiting list within 18 weeks	Organisation specific target to aid delivery towards 92% by Mar-29 Halfway between 92% and Mar-27 target or plan, whichever is higher	Mar-28	80.70%	75.40%
28-day cancer Faster Diagnosis Standard	Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%	Average across 2027/28	80.00%	81.15%
Percentage of patients receiving a first definitive treatment for cancer within 62 days	Every trust delivering 82.5% performance for 62-day standards	Mar-28	82.50%	81.57%
Percentage of people treated beginning first or subsequent treatment of cancer within 31 days	Every trust delivering 96% performance for 31-day standard	Mar-28	96.00%	95.27%
Total Waiting List	Year-on-year reduction Baseline is Mar-27 plan	Mar-28	21,181	22,582
Average handover time (Total Handover time (ED and non ED)/No of handovers (ED and non-ED)	Plans to be assured by measuring year-on-year improvement in average handover time Baseline is 2026/27 planned average	Average across 2027/28	00:11:47	00:11:17

- Targets and QVH submitted performance plan

Business Planning Approach
- QVH Internal Budget Setting Approach

Business Planning Elements - Control Totals

Queen Victoria Hospital NHS Foundation Trust

Control totals

- Create a control total for each directorate.
- Use 2026/27 M6 run rates / FOT
- Apply full year effects of 2026/27 cost pressures and service developments
- Remove one off costs
- Apply assumptions use 2026/27 national guidance (e.g.)
  - Pay inflation 2.9%
  - Non pay inflation 0.5%
  - Income inflation
  - Efficiency income reduction
- Update assumptions for NHSE guidance updates
- Add revenue costs from approved capital programme
- Add an investment reserve of 3% initially
- Add better value target % to achieve breakeven
- Add workforce WTE envelope

The Trust needs to achieve breakeven so plans when combined need to deliver this. Additional costs or loss of income will need to be covered by activity or an increase to the better value programme.

Business Planning Elements – Financial, Workforce & Activity plans

Queen Victoria Hospital NHS Foundation Trust

Pay, Non Pay and income

- Baseline – Initial budget provided inline with 2026/27 run rate
- Inflation increased as per NHS guidance 2026/27 (Update when received)
- Non recurrent items adjusted
- Updated for FYE of service developments and cost pressures from 2025/26
- Add significant service changes
- Compare budget with actual and provide summary/proposal of adjustments for significant run rate variances
- Apply Better value targets

Build workforce

- Baseline – Initial budget provided inline with 2026/27 outturn
- Review budgets and ensure WTE aligns with budgets
- Update WTE for 2026/27 Better value adjustments
- FYE of service developments from 2026/27
- Add significant service changes

Activity

- Build activity plans to align to demand and capacity modelling
- Cost up plans

Triangulate

- Compare across all three areas to ensure alignment

Business Planning Elements – Service Developments/Cost Pressures

Queen Victoria Hospital NHS Foundation Trust

Cost Pressures

- Directorate leads to identify significant cost pressures required to deliver the activity plans
- Cost pressure assumption is that all will be covered by Directorates internally
- A review will be made of the cost pressures and a small number of key/significant pressures will be funded centrally
- Directorates will be informed of any central funding being allocated
- Control Totals will be updated for any allocated funding

Service Developments

- Identification of service developments that are self financing and funded by directorate
- Service developments submitted on POAP with cost and WTE
- Directorate teams to review and prioritise before submitting for Trust review
- New service developments to be submitted to a review group for approval
- Directorate control totals to be adjust for approved plans
- Budget, activity and WTE plans to be updated for approved plans

Significant changes will require a full business case

Business Planning Elements – Better Value programme

Queen Victoria Hospital
NHS Foundation Trust

- Better Value target to be allocated to each directorate.
- Directorate leadership team to build detailed plans on BV forms including phasing
- These are to include EQIA
- Forms to be submitted to the Business planning group for review
- Approved plans to be incorporated in the budget, activity and workforce plans
- Trust tracker to be updated for plans
- Better value needs to reduce the budget in the initial upload to close the gap to the control total.
- Any Trust wide schemes will be used to support the delivery of the local better value programme.

Challenge meetings

Queen Victoria Hospital
NHS Foundation Trust

Multi-faceted Engagement and Sign-off Approach

- Submissions will be made inline with the timetable (tbc)
- Submissions to include the
  - Directorate business plan
  - Detailed budget and WTE
  - Detailed activity plans
  - Better value programmes
- Review meetings in the diary will be used to run challenge and review sessions on the submitted paperwork
- Challenge to be provided by DCFO, DCOO, DCPO and members of ELT.

Key Planning Milestones

Queen Victoria Hospital
NHS Foundation Trust

Budget setting milestones	Date
Business Planning Launch email	30-Oct-26
Submission of investment requirements	30-Nov-26
Submission of Initial business plans, budgets, activity, workforce	24-Dec-26
Develop detailed Better value programme	Jan-26
Finalise capital programme detail	Feb-26
Sign off Budgets by directorates	Mar-27
Upload Budgets	Apr-27

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026		**Agenda reference:**	**96-26**	
Report title:	Quality and safety committee assurance				
Sponsor:	Jo Emmanuel, Non-executive Director, committee Chair				
Author:	Jo Emmanuel, Non-executive Director, committee Chair Katie Ally, Governance Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	– The Committee reviewed elective recovery performance and noted that RTT, diagnostic and cancer standards remain below planned trajectories, with long waits and capacity pressures continuing to require oversight. – Assurance was received regarding quality governance, patient safety, workforce oversight and organisational risk, including progress against the Trust's Quality Priorities and Continuous Improvement Programme. – Limited assurance was received regarding the management of historical patient safety incidents. Whilst progress has been made in reducing the backlog of open incidents, further work is required to strengthen the timeliness of investigations and completion of harm assessments. – Positive patient experience outcomes were noted through the Annual National Inpatient Survey, alongside continued progress in addressing health inequalities. – The Committee reviewed the Quality strategic risk and recommended reduction of the Board Assurance Framework risk score to the target level following progress against agreed mitigations.				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	*To innovate and improve*	*To be an excellent employer*	*To deliver sustainable services*	*To collaborate with others*
Implications					
Board assurance framework:	The committee reviewed the BAF risk relevant to its remit at the meeting				
Organisational risk register:	The committee received the organisational risk register at the meeting.				
Regulation:	None				
Legal:	None				
Resources:	None				

Sub-committee assurance report
Quality & Safety committee - 3 November 2026

Key agenda items

- **Elective recovery update**
- **Executive Committee for Quality & Risk matters to raise with the committee**
- **Integrated Quality & Performance Report**
- **Quality Priorities delivery progress – Quarter 2 2026/27**
- **Continuous improvement initiatives -Biannual update**
- **Guardian of Safe Working Hours Report including update on resident doctors 10 point plan***
- **Mortality report***
- **Patient safety overview & update – Quarter 2 2026/27**
- **Annual Flu vaccination planning and performance***
- **Safeguarding (Adult and Children) 2026/27 – update**
- **Health & Safety action plan – update**
- **Annual National Inpatient Survey Report***
- **Patient Experience update (Claims and complaints)**
- **Quality Impact Assessment – Quarterly update**
- **Biannual assessment of addressing Health Inequalities (inc. lessons learnt)**
- **Board Assurance Framework & Organisational Risk Register**

Alert

- The Committee discussed elective recovery performance and noted that RTT, diagnostic and cancer standards remain below planned trajectories. The Committee requested ongoing assurance regarding delivery of recovery plans and the management of associated patient risks.
- The Committee noted continued growth in long waits and received assurance regarding arrangements to identify, monitor and mitigate risks for patients experiencing extended waits for treatment. Ongoing oversight was requested in relation to quality, safety and patient experience impacts.
- The Committee reviewed progress against the 2026/27 staff flu vaccination programme and noted that uptake remains below the emerging national ambition. Continued focus is being maintained to maximise staff participation ahead of the winter period.
- Sustained demand and capacity pressures continue to present a risk to achievement of key access standards, and ongoing oversight has been requested through established governance arrangements.

Assure

- Effective governance arrangements remain in place to oversee quality, patient safety and organisational risk, including oversight of the Board Assurance Framework, Quality Priorities and key performance and risk indicators.
- The Committee received assurance regarding progress against the Trust's Quality Priorities and noted continued development of quality improvement activity, governance arrangements and outcome reporting.
- The Continuous Improvement Programme continues to demonstrate positive progress in capability building, staff engagement and delivery of improvement initiatives, whilst further work is underway to embed a sustainable culture of improvement across the organisation.

- Robust arrangements remain in place to oversee resident doctors' working hours, exception reporting and rota safety. Recognised workforce pressures continue to be monitored and managed through established governance processes.
- The Committee received assurance that no matters requiring escalation were identified through the mortality review process during the reporting period.
- Limited assurance was received regarding the management of historical patient safety incidents. Whilst progress has been made in reducing the backlog of open incidents, further work is required to strengthen the timeliness of investigations, harm assessment processes and organisational learning. A further update has been requested.
- Safeguarding priorities, health and safety arrangements, complaints and claims activity continue to be monitored through established governance arrangements, with ongoing oversight of key themes, risks and improvement actions.
- Revised Quality Impact Assessment arrangements have strengthened oversight of quality impacts arising from the Better Value and Recovery programmes, with ongoing work to complete outstanding assessments and strengthen evidence of impact.

Advise
- Results from the Annual National Inpatient Survey demonstrate positive patient experience outcomes, with performance above national benchmarks in a number of areas whilst identifying opportunities for further improvement.
- Progress continues to be made in addressing health inequalities across the Trust. Ongoing work remains focused on understanding and reducing variation in access, experience and outcomes, with delivery monitored through established governance arrangements

Risks discussed and new risks identified
The Committee reviewed the Quality strategic risk and, noting progress against agreed mitigations and improvements in quality governance and organisational assurance, recommended reduction of the Board Assurance Framework risk score to the target level. The Committee emphasised the importance of maintaining robust oversight of organisational change and its impact on quality, safety and patient experience through established governance arrangements.

Recommendation
The Board is asked to **note** the contents of the report

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**97-26**		
Report title:	Financial, workforce and operational performance assurance				
Sponsor:	Nick Page, Non-executive Director, committee Chair				
Author:	Nick Page, Non-executive Director, committee Chair Katie Ally, Governance officer				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	– The committee received assurance on the RTT Recovery Plan and ongoing actions to support delivery of RTT, diagnostic and cancer recovery trajectories in the context of continued demand and capacity pressures. – Financial performance remains in line with plan, with continued focus on delivery of efficiency, CIP and Better Value Programme targets. – Strategic partnership arrangements with ASPH and RSFT have commenced, with a focus on benefits realisation, risk management and delivery oversight. – Progress was noted across major strategic programmes, including the Community Diagnostic Centre, PAS implementation and Digital Transformation Programme, with ongoing monitoring of delivery risks. – Assurance was received regarding estates compliance, infrastructure management and delivery of the Premises Assurance Model improvement plan. – The committee received assurance on security management arrangements, including high compliance with the Violence Prevention and Reduction Framework. – The Board Assurance Framework and Corporate Risk Register were reviewed, with continued oversight of key strategic and operational risks				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	*To innovate and improve*	*To be an excellent employer*	***To deliver sustainable services***	*To collaborate with others*
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Sub-committee assurance report
Finance and Performance Committee – 2 November 2026

Key agenda items

- **RTT Recovery Plan 2026/27**
- **Integrated Quality & Performance Report – Month 5 and Month 6 outlook**
- **Cost Improvement Programme (CIP) update & Recovery Plan**
- **Partnership benefits realisation**
- **Major Projects update**
    - **East Grinstead Community Diagnostic Centre**
    - **MRI Scanner**
    - **Digital Transformation incl. Patient Administration System and benefits realisation**
    - **Sussex Pathology Network (SPN)**
- **Business Planning 2027/28**
- **Estates assurance – critical infrastructure delivery**
- **Local Security Management Specialist (LSMS) work plan 2026/27**
- **Review of Board Assurance Framework and Organisational risk register**

Alert

- The committee discussed the RTT Recovery Plan and noted the ongoing challenges associated with delivery of year-end RTT performance trajectories. Members considered the impact of continued demand and capacity pressures and reviewed the actions being taken to support recovery. The committee received partial assurance that appropriate recovery actions and oversight arrangements are in place and will continue to monitor progress closely and recommended further board discussion.
- The committee received limited assurance that the Trust remains on track to achieve its planned year-end financial position. Whilst the Month 6 position is in line with plan, risks remain around workforce expenditure, delivery of planned savings and the achievement of forecast assumptions during the second half of the year. The committee requested further detail on capital expenditure plans and will continue to monitor financial performance and associated risks closely
- The committee acknowledged the actions being taken to strengthen delivery of the Better Value/CIP programme, however significant work remains to translate identified opportunities into fully quantified and deliverable schemes, with risks remaining to delivery of the full programme and forecast position. Whilst management is pursuing a range of workforce and establishment-related savings initiatives, further evidence is required to demonstrate that the cumulative impact of these actions will be sufficient to achieve the required level of recurrent savings. The committee will continue to monitor delivery and associated risks closely.

Assure

- The committee received assurance that Business Planning for 2027/28 is progressing and that key assumptions are being developed through demand and capacity modelling and commissioner engagement. The committee noted that significant uncertainty remains regarding national planning requirements, financial targets and future performance expectations, and requested further detail on the quantification of risks, workforce implications and delivery plans as planning assumptions become clearer.

- The committee received partial assurance regarding the major projects portfolio. Significant progress has been made across a number of strategic programmes, including the East Grinstead Community Diagnostic Centre, though a number of projects remain subject to funding, procurement and delivery risks. The committee approved a proposed variance of £450k in 2026/27 and £280k in 2027/28 to complete the PAS project, noting that capital funding has been identified, and requested ongoing reporting on programme risks, funding assumptions and delivery milestones to support continued oversight and assurance.
- The committee reviewed the Premises Assurance Model (PAM) improvement plan and approved the structured action tracker as the Trust's improvement plan to address identified compliance gaps. It provides clear ownership and monitoring arrangements. While further work is required to strengthen assurance documentation and evidence, no immediate high-risk concerns were identified that would prevent delivery of safe patient services.
- The Estates assurance report confirmed continued progress in addressing critical infrastructure and fire safety priorities through a risk-based investment approach.

Advise

- The committee discussed the partnership benefits programme. Whilst there is evidence of increasing collaboration across the Group and emerging opportunities in clinical, workforce and corporate services, the committee noted that many anticipated benefits remain unquantified and require further development. Additional assurance was sought regarding the scale, timing and delivery of both financial and non-financial benefits, and further reporting on benefits realisation has been requested.
- The committee received assurance regarding the Local Security Management Specialist work programme, noting achievement of 98% compliance against the Violence Prevention and Reduction Framework, with only one outstanding action remaining.

Risks discussed and new risks identified

The Committee discussed the following principal risks:

- Risks to delivery of RTT, diagnostic and cancer performance trajectories arising from sustained demand and capacity pressures.
- Delivery risk associated with the Better Value/CIP programme and achievement of the full-year recovery plan.
- Delivery risks associated with the East Grinstead Community Diagnostic Centre programme.
- Ongoing PAS implementation risks within the Digital Transformation Programme.
- Strategic risks contained within the Board Assurance Framework. The Committee supported the proposed reduction in the Estates strategic risk score from 16 to 12, reflecting improved assurance regarding estates compliance, safety and leadership capacity.

Recommendation

The Board is asked to **note** the contents of the report

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**98-26**		
Report title:	Strategy and culture assurance				
Sponsor:	Angela McNab, Deputy Trust Chair and committee Chair				
Author:	Ellie Simpkin, Governance manager				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	- Material progress has been made in the delivery of all five Key Strategic Objectives (KSOs) during the first half of 2026/27. The committee emphasised the importance of considering the longer-term strategic response to current challenges and ensuring future strategic priorities align with the ambitions of the NHS 10-Year Health Plan. - Mobilisation of the strategic partnership continues across clinical, corporate and cultural workstreams. The committee highlighted the importance of developing a robust Benefits Realisation Framework that captures both tangible and less tangible benefits, supporting effective evaluation, reporting and Board oversight. - The committee has reviewed the Annual Equalities Report 2025/26 and recommends that the Board approves the report for publication. The committee discussed opportunities to make greater strategic use of equality and demographic data to inform future service development and planning. - The committee recommends that the Board adopts the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism and the Government's non-statutory working definition of anti-Muslim hostility. - The committee recommends reducing the Leadership Capacity Board Assurance Framework (BAF) risk score from 16 to 12 and the Sustainability & Strategy BAF risk score from 16 to 12, reflecting progress in strategic partnership implementation, leadership arrangements and organisational development.				
Recommendation:	The Board is asked to **note** the contents of the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:** *To deliver outstanding care*	**KSO2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	**KSO4:** ***To deliver sustainable services***	**KSO5:** ***To collaborate with others***
Implications					
Board assurance framework:	The committee has reviewed the BAFs relevant to its remit.				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Sub-committee assurance report
Strategy & culture committee – 29 October 2026

Key agenda items

- **Partnership update**
- **QVH Strategy 2025-2030: Year 2 delivery update**
- **Annual Equalities Report 2025/26**
- **Lord Mann Review - adoption of the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism and the Government's non-statutory working definition of anti-Muslim hostility**
- **Board Assurance Framework**

Alert

- The committee reviewed progress against delivery of the *QVH Strategy 2025-2030* during the first six months of 2026/27. Material progress has been made across all five Key Strategic Objectives (KSOs). Operational performance, financial sustainability and the delivery of the Trust's major projects will continue to be key areas of focus for the remainder of the financial year. The committee emphasised the importance of considering the longer-term strategic response to current challenges alongside the implementation of in-year operational measures, ensuring that delivery of the Trust's KSOs are clearly aligned with the wider NHS context, including the ambitions and direction set out within the NHS 10-Year Health Plan.

Assure

- Mobilisation of the strategic partnership continues and work is progressing across clinical, corporate and cultural workstreams. Seven priorities have been developed for the first three to six months of partnership expansion and the Benefits Realisation Framework is being developed. Communications and engagement activity is supporting the transition to shared leadership and the next phase of implementation. The committee has highlighted the importance of capturing both the tangible benefits and less tangible benefits and suggested that benefits are categorised to support meaningful evaluation, reporting and oversight.

Advise

- The committee has reviewed the Annual Equalities Report 2025/26 and recommends to the Board that it approves the report for publication on the Trust's website. The committee discussed opportunities to further develop the use of equality and demographic data to inform future strategic planning, service development and understanding of the populations served by the Trust.
- The committee recommends to the Board of Directors the adoption of the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism, and the Government's non-statutory working definition of anti-Muslim hostility.

Risks discussed and new risks identified

The committee reviewed BAF risks which relate to the long term sustainability of the Trust, leadership capacity and workforce, noting the key actions being taken to address gaps in assurance. The committee recognised the progress which continues to be made to strengthen the management and oversight of strategic risks.
The committee recommends to the Board that the current risk score for the Leadership Capacity BAF is reduced from 16 to 12 and the Sustainability & Strategy

BAF risk score is reduced from 16 to 12, reflecting the progress which has been made in strategic partnership implementation, leadership arrangements and organisational development.

Recommendation
The Board is asked to **note** the contents of the report.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**99-26**		
Report title:	Audit and risk assurance				
Sponsor:	Jagjit Dosanjh-Elton, Non-Executive director and committee Chair				
Author:	Ellie Simpkin, Governance manager				
Appendices:	None				
Executive summary					
Purpose of report:	To alert, assure and advise the Board regarding matters considered at the last committee meeting.				
Summary of key issues	- The committee has highlighted the importance of ensuring that the Board receives sufficient assurance on delivery of the financial recovery plan. - Whilst the overall assurance opinion for estates compliance is Moderate Assurance with improvement required, significant work is being undertaken to establish compliance baselines, strengthen assurance arrangements and prioritise gaps taking a risk-based approach. - The committee has requested further information on cyber risk management, including a proposed action plan and communication plan in an event of a cyber attack. - The Trust's Board Assurance Framework and risk management arrangements continue to mature, supported by a Reasonable Assurance opinion from Internal Audit.				
Recommendation:	The Board is asked to **note** the contents of the report				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	*To innovate and improve*	*To be an excellent employer*	***To deliver sustainable services***	*To collaborate with others*
Implications					
Board assurance framework:	The committee reviewed the latest BAF relevant to its remit at the meeting.				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Sub-committee assurance report
Audit & risk committee – 22 September 2026

Key agenda items

- **Key matters from Board, sub-committees & Executive committee for quality & risk**
- **Board Assurance Framework (BAF) - update on key strategic risks**
- **Assurance on risk management framework incl. overview of risk landscape**
- **Estates compliance / assurance**
- **Financial assurance**
- **Internal audit progress report**
- **Local Counter Fraud progress report**

Alert

- The committee highlighted the importance of ensuring that the Board is sufficiently assured on the delivery of the Trust's financial recovery plan, noting the importance of understanding how delivery of the financial recovery plan aligns with the management of organisational risks and the actions required to deliver the Better Value Plan.
- The committee requested further information on cyber risk management, including the including a proposed action plan and communication plan in an event of a cyber attack.

Assure

- The committee is assured that the Trust's Risk Management Framework continues to mature, with the Board Assurance Framework being reviewed collectively through Executive Team huddles and changes in reporting format which is supporting better conversations at Board Sub-committees. There is continued focus on ensuring risks are regularly reviewed, actions are completed and registers distinguish strategic and operational risks from day-to-day issues. The most recent internal audit review of the Trust's BAF and risk management arrangements received an overall opinion of Reasonable Assurance.
- The committee welcomed reporting on estates compliance and assurance which clearly articulated areas of assurance and where gaps remain. Whilst the overall assurance opinion for estates compliance is Moderate Assurance with improvement required, significant work is being undertaken to establish compliance baselines, strengthen assurance arrangements and prioritise gaps, taking a risk-based approach. A structured compliance improvement programme is now established with clear governance arrangements, executive oversight and defined remediation plans.
- The Trust continues to sustain a reduction in the use of Single Tender Waivers. A financial assurance dashboard has been developed which now provides a clear overview of the Trust's procurement compliance.
- The internal audit review of the Pharmacy and Medicines Management received a Reasonable Assurance opinion with management actions agreed to address the identified areas for improvement.
- The committee received assurance regarding counter fraud activity. Benchmarking of the compliance rate for mandatory declarations of interest shows that the Trust's compliance rate of 97% was above the subsector average of 87%.

Advise

- A review of the Trust's risk appetite is due and an externally facilitated session for the Board will be arranged to support this work.
- The Trust's Scheme of Delegation and Reservation of Powers will be reviewed to reflect the changes in the Trust's leadership as part of the strategic partnership.

Risks discussed and new risks identified

The committee reviewed the Board Assurance Framework and Organisational Risk Register, with particular focus on estates, cyber security and regulation risks. The committee welcomes the introduction of the actions most likely to reduce strategic risk to reporting.

Recommendation

The Board is asked to **note** the contents of the report.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026		**Agenda reference:**	**100-26**	
Report title:	Guardian of Safe Working Hours Report incl. update on resident doctors 10 point plan				
Sponsor:	Tamara Everington, Managing Directory & Chief Medical Officer				
Author:	Jennifer O'Neill, Guardian of Safe Working Hours (GOSW) (with Lydia Rome and Sarah Oliphant (HR) and Helen Moore (Medical Education manager))				
Appendices:	Appendix 1 - GOSW hours report - Quarter one 2026/27 Appendix 2 - GOSW hours report - Quarter two 2026/27				
Executive summary					
Purpose of report:	To assure that we are following national standards for resident doctors and monitoring work schedules, rota gaps, locum use and exception reports				
Summary of key issues	The Trust has implemented the nationally updated exception reporting process using Allocate (a recognised software system). Key safe-working issues continue to be monitored. Long free-tissue-transfer cases in lower limb and breast reconstruction Plastic Surgery and Maxillofacial Surgery can result in late finishes and breaches of contracted hours. Overnight non-resident on-call activity can also affect mandated rest periods, and Plastic Surgery handovers occasionally overrun despite an additional 15 minutes being built into the rota. The GOSW is working with residents to ensure compensatory rest or immediate TOIL is arranged promptly where required. Where an unfilled on-call rota gap arises (and cannot be solved) the formal 'acting down policy' must be enacted, with a named doctor in each post. Residents must not be expected to cover both middle-grade and junior resident roles simultaneously. Such instances have been very infrequent, investigated and reported, with no known safety incidents, but the arrangement is not acceptable for patient or doctor safety. Other actions include additional theatre lockers, in line with the resident 10-point plan; correction and review of August pay errors affecting new starters, particularly in Anaesthetics; and further work to improve resident rest facilities.				
Recommendation:	The Board is asked to **note** the issues and actions above and take assurance that there are no immediate recent rota safety concerns. The position continues to be monitored.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: ***To deliver outstanding care***	KSO2: *To innovate and improve*	KSO3: ***To be an excellent employer***	KSO4: ***To deliver sustainable services***	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	Safe rotas				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	HR/ recruitment for staffing levels and data				
Assurance route					
Previously considered by:	ELT, Quality & safety committee				
	Date:	October 2026	Decision:	Submit to Board	
Next steps:					

Guardian of Safe Working Hours Report incl. update on resident doctors 10 point plan

Situation

The Guardian of Safe Working Hours (GOSW) continues to provide oversight of resident doctors' working hours, rota arrangements and exception reporting. National guidance and local processes continue to be reviewed to support compliance with contractual requirements and safe patient care. During this reporting period, the Trust has continued to use the nationally updated exception reporting process through Allocate.

Background

The GOSW role provides independent assurance to the Trust on the safe working of resident doctors. This includes oversight of working hours, work schedules, rota gaps and exception reporting, together with identification and escalation of risks to resident wellbeing or patient safety. Regular reporting to the Quality and Safety Committee supports assurance that appropriate systems are in place and that emerging risks are identified, investigated and managed in a timely manner.

Assessment

Exception reporting continues to provide a mechanism for identifying deviations from contracted working hours, with payment or time off in lieu (TOIL) provided where appropriate and contractual fines applied in accordance with national requirements.

A number of recurring safe-working themes remain under review. Long free-tissue-transfer cases in the lower limb and breast reconstruction plastic surgery service and long oncology cases in Maxillofacial Surgery can result in unplanned late finishes and breaches of contracted hours, including shifts exceeding the maximum 13-hour duration. Overnight activity during non-resident on-call shifts for Maxillofacial Surgery and Plastic Surgery registrars can also affect mandated rest requirements. Plastic Surgery handovers may occasionally overrun despite an additional 15 minutes having been incorporated into the rota. The GOSW is working with residents to strengthen arrangements so that compensatory rest is planned promptly following an event, including immediate TOIL where required, and work-schedule adjustments will continue to be considered where appropriate.

Where short staffing creates an on-call rota gap that cannot be filled, the formal 'acting down policy' must be enacted to ensure that there is a named doctor in each required post. Resident doctors must not be expected to cover both middle-grade and junior resident roles simultaneously. This has occurred very infrequently in Plastic Surgery and Maxillofacial Surgery, and each occurrence has been investigated and reported. No known patient safety incident has resulted; however, this arrangement is not considered acceptable for either patient safety or the wellbeing of the doctor involved, and appropriate forward planning remains important.

Progress continues against the Trust's 10-point plan for improving resident working conditions. The number of theatre lockers has been increased so that residents have access to secure storage in a suitable location. This is particularly timely following reports of thefts of clothing and shoes from the changing-room area. Further improvement is still required in relation to resident rest facilities.

Preventing and promptly resolving pay errors is also an important element of the 10-point plan. A number of new starters in August, particularly in Anaesthetics, experienced pay errors. These are being rectified; however, resolving them has been

time-consuming for affected residents and has caused financial difficulty. The process for transferring workforce information to the external payroll provider should therefore be reviewed to identify opportunities to prevent recurrence and enable faster resolution where problems arise.

Although the 10-point plan does not officially fall within the remit of the Guardian of Safe Working (GOSW), it is important to the experience of Resident Doctors and, consequently, to safe working. It also overlaps with issues discussed with the GOSW at the Resident Doctor Forum.

Overall, robust arrangements remain in place to monitor working hours, review exception data, investigate contractual breaches and escalate safe-working concerns. No immediate or unresolved rota safety risks have been identified during this reporting period. The GOSW will continue to monitor trends and escalate concerns where required.

Recommendation
The Board is asked to note the issues and actions described above and take assurance that there are no immediate recent rota safety concerns. The position continues to be monitored by the GOSW.

NHS Employers

Exception reporting

Reporting requirements

Exception reporting applies to all doctors and dentists in training (referred to collectively hereafter as ‘the doctor’) who are substantively employed under the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (“2016 TCS”) and to those whom the provision has been extended locally. It is recognised that the 2016 TCS are widely mirrored in other employment contexts, and we encourage employers in England to make every effort to extend exception reporting where appropriate.

The purpose of exception reporting is to ensure prompt resolution and / or remedial action to ensure safe working hours are maintained, secure patient safety, and safeguard the delivery of agreed educational opportunities. Exception reporting is also the mechanism used by doctors to ensure compensation for all work performed and uphold agreed educational opportunities.

This exception reporting guidance is intended to provide direction and advice on how to interpret and implement the changes to exception reporting being enacted via version 13 of the 2016 TCS. This guidance seeks to provide recommendations and best practice approaches to implementing and adhering to these changes.

The overriding principle of these changes is to trust doctors to conduct themselves professionally, and to remove previously existing barriers to exception reporting.

NHS Employers

This guidance is intended for use by the Guardian of safe working hours' (GoSWH) to create reports for their Trust Board on a quarterly and annual basis. The GoSWH quarterly report and annual summary reports are standardised to a national template to allow central data processing.

The contractual terms are effective from 4 February 2026 and monitoring requirements should subsequently start from 1 April 2026. Sections:

1. Quarterly reporting requirements

2. Annual reporting requirements

3. Recipients of quarterly and annual Board reports

1. Quarterly reporting requirements

This report is made jointly by the Guardian of Safe Working (GOSW) Miss Jennifer O'Neill and the specialist work force data provided by Lydia Rome Medical Workforce Administrator

High level data for QVH

Number of doctors / dentists in training (total):	67 (47 HEE 20 Trust)
Number of doctors / dentists in training on 2016 contract (total):	67 (47 HEE 20 Trust)
Amount of time available in job plan for guardian to do the role:	0.75 PAs / 3 hours per week
Admin support provided to the guardian (if any):	Ad hoc
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

*excludes Radiology HEE trainees, lead employer UHSx facilitates the exception reporting.

a) Number of exception reports submitted

The GoSWH will have access to all exception reports and will review and scrutinise exception reporting patterns to ensure reports are accurate, valid and adhere with the purpose of exception reporting.

Number of exception reports submitted over the last quarter:	**34 (2 tests)**

NHS Employers

NHS Employers

b) Categories of exception reports submitted

Supporting information

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start	0	0	0	0	0
Additional hours an unscheduled late finish	29	0	0	0	29
Breaches of non-resident on-call patterns	0	0	0	0	0
The inability to take contractual breaks	0	0	0	1	1
Inadequacy of clinical support	0	0	0	1	1
Inadequacy of rostered skills mix	0	0	0	0	0
Raising concerns of a suspected non-compliant rota pattern	0	0	0	0	0
Detriment or threat of detriment related to exception reporting	0	0	0	0	0
Information breach	0	0	0	0	0

Access and completion resolved in time	0	0	0	0	0
Access and completion breaches	0	0	0	0	0
Access and completion test	0	0	0	0	2
Missed Educational Opportunities	0	0	0	2 (and replaced opportunities 1)	3
Total					34 (2 tests)

c) Experiences of actual or threatened detriment

One of the guiding principles of the exception reporting reforms is to prevent doctors experiencing, either threatened or actual, detriment as a result of exception reporting or indicating intent to exception report. Detriment in an employment context is when an employer, or colleagues, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right.

Quarterly survey response rate	15% (10/67)
Doctors experiencing actual detriment as a result of exception reporting	1 of the 10 responses said ‘maybe’ . 9 said no detriment
Doctors feeling that they are not discouraged from exception reporting	1 response saying negative attitude to exception reporting from seniors. 2 responses saying they feared it would impact training opportunities. 2 responses saying the feared impact on rota, leave or workload for others.

d) Withdrawals

A doctor can choose to withdraw an exception report that they have submitted at any point in the process following submission. All exception reporting data, including those which have been withdrawn, will be retained for the GoSWH to allow them to perform their role in checking for potential safety implications.

Number of exception reports withdrawn over the last quarter	0

e) Access to individual doctors ’exception reporting data

Personally identifiable datarelated to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.

The affected doctor should be notified of this action as soon as practically possible, and the number of such disclosures must be presented in a manner that preserves a doctors' anonymity.

Number of exception reports disclosures over the last quarter	0

f) Work schedule reviews related to exception reporting pattern/instances

The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.

Number work schedules reviews related to exception reporting patterns or instances	Maxfax have locally been reviewing their work schedules under the surgical tutor.

g) Rota gaps on all shifts

Total number of rota gaps on all shifts over the last quarter	247

h) Additional information on an ad hoc basis

The GoSWH is required to report any escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level.

Details N/A
Free text

The GoSWH is required to report issues, with certain posts, that cannot be remedied locally and require a system-wide solution. The board is required to raise the system-wide issue with partner organisations (for example, NHS England) to find a solution.

Details N/A

NHS Employers

Free text

NHS Employers

2. Annual reporting requirements

The GoSWH quarterly report (including annual summary reports) will be standardised to a national template jointly produced in guidance to allow central data processing.

The recipients of annual summary reports are detailed in section 3 of this guidance.

a) Disbursement of fines

The details of the GoSWH fines will be published in the organisation's annual financial report (accounts), which are subject to independent audit. The GoSWH annual report will include clear detail on how the money has been spent. (Schedule 5 paragraph 31)

Annual financial report requirements

Addendum 16/10/26: This has been updated to show that there were two deanery Q1 fines for extra hours that have now been processed and amounted to £746.40. No fine money was spent.

Fine	Number of fines applied	Value of fines applied
Additional hours worked breach	2	746.40 to the Guardian fine pot
Information breach	0	0

Access and completion breach	0	0
Missed breaks breach	0	0
Total	0	0

Annual report requirements

Work schedule reviews relating to education and training
The DME shall report annually to the board on all work schedule reviews relating to education and training.

Number of work schedule reviews related to education and training	0

c) Rota gaps

A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the trust's quality account, which must be signed off by the trust's chief executive.

Total number of rota gaps on all shifts over the last year	247

NHS Employers

Count of Request Reason	Apr	May	Jun	Grand Total
Additional Clinic List - Sat/Sun	12	16	10	38
Additional Clinic List - Weekday	19	12	9	40
Additional Clinic/List		1		1
Annual Leave	3		1	4
Cleared Demand	3	1	5	9
Emergency Leave		1	1	2
Industrial Action	12		7	19
Maternity			1	1
On Call	8	10	1	19
Other/Please state in the note	28	18	10	56
Paternity	3			3
Rota Gap - LTFT Trainee			3	3
Rota Gap - On Call Rota	1		1	2
Sickness	10	13	7	30
Special Leave		1	5	6
Study Leave			1	1
Training	1		1	2
Transport Patient	1			1
Vacancies	2	4	4	10
Grand Total	103	77	67	247

NHS Employers

3. Recipients of board reports

All quarterly reports must be publicly accessible online within one month after the report has been created.

Information to be shared	Recipient(s) of board reports	Frequency
Quarterly reports	• This report must be sent directly to: • the Joint Local Negotiating Committee (JLNC) • the Local Negotiating Committee (LNC) chair • at least one nominated LNC resident doctor, and relevant RDF representatives upon completion. • DHSC/NHS England • NHS England (Local office), Care Quality Commission, General Medical Council and General Dental Council. • In addition, all quarterly reports must be publicly accessible online within one month after the report has been created.	Quarterly

Issues identified as a result of exception reporting that cannot be remedied locally and require a system-wide solution	LNC The board will raise the system-wide issue with partner organisations (eg NHS England) to find a solution.	Ad hoc
Annual reports	DHSC/NHS England local offices of NHS England, the Care Quality Commission, the General Medical Council and the General Dental Council.	Annual

NHS Employers

Exception reporting

Reporting requirements

Exception reporting applies to all doctors and dentists in training (referred to collectively hereafter as ‘the doctor’) who are substantively employed under the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (“2016 TCS”) and to those whom the provision has been extended locally. It is recognised that the 2016 TCS are widely mirrored in other employment contexts, and we encourage employers in England to make every effort to extend exception reporting where appropriate.

The purpose of exception reporting is to ensure prompt resolution and / or remedial action to ensure safe working hours are maintained, secure patient safety, and safeguard the delivery of agreed educational opportunities. Exception reporting is also the mechanism used by doctors to ensure compensation for all work performed and uphold agreed educational opportunities.

This exception reporting guidance is intended to provide direction and advice on how to interpret and implement the changes to exception reporting being enacted via version 13 of the 2016 TCS. This guidance seeks to provide recommendations and best practice approaches to implementing and adhering to these changes.

The overriding principle of these changes is to trust doctors to conduct themselves professionally, and to remove previously existing barriers to exception reporting.

NHS Employers

This guidance is intended for use by the Guardian of safe working hours' (GoSWH) to create reports for their Trust Board on a quarterly and annual basis. The GoSWH quarterly report and annual summary reports are standardised to a national template to allow central data processing.

The contractual terms are effective from 4 February 2026 and monitoring requirements should subsequently start from 1 April 2026. Sections:

1. Quarterly reporting requirements

2. Annual reporting requirements

3. Recipients of quarterly and annual Board reports

1. Quarterly reporting requirements

This report is made jointly by the Guardian of Safe Working (GOSW) Miss Jennifer O'Neill and the specialist work force data provided by Lydia Rome Medical Workforce Administrator

High level data for QVH

Number of doctors / dentists in training (total):	66 (49 HEE 17 Trust)
Number of doctors / dentists in training on 2016 contract (total):	66 (49 HEE 17 Trust)
Amount of time available in job plan for guardian to do the role:	0.75 PAs / 3 hours per week
Admin support provided to the guardian (if any):	Ad hoc
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

*excludes Radiology HEE trainees, lead employer UHSx facilitates the exception reporting.

a) Number of exception reports submitted

The GoSWH will have access to all exception reports and will review and scrutinise exception reporting patterns to ensure reports are accurate, valid and adhere with the purpose of exception reporting.

Number of exception reports submitted over the last quarter:	**43**

NHS Employers

b) Categories of exception reports submitted

Supporting information

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start	2	0	1	0	2
Additional hours an unscheduled late finish	26	2	13	0	41
Breaches of non-resident on-call patterns	0	0	0	0	0
The inability to take contractual breaks	0	0	0	2	2
Inadequacy of clinical support	0	0	0	1	1
Inadequacy of rostered skills mix	0	0	0	0	0
Raising concerns of a suspected non-compliant rota pattern	0	0	0	0	0
Detriment or threat of detriment related to exception reporting	0	0	0	0	0
Information breach	0	0	0	0	0

Access and completion resolved in time	0	0	0	0	0
Access and completion breaches	0	0	0	0	0
Access and completion test	0	0	0	0	0
Missed Educational Opportunities	0	0	0	0	0
Total					47

c) Experiences of actual or threatened detriment

One of the guiding principles of the exception reporting reforms is to prevent doctors experiencing, either threatened or actual, detriment as a result of exception reporting or indicating intent to exception report. Detriment in an employment context is when an employer, or colleagues, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right.

Quarterly survey response rate	6% (4/67)
Doctors experiencing actual detriment as a result of exception reporting	0
Doctors feeling that they are not discouraged from exception reporting	0

d) Withdrawals

A doctor can choose to withdraw an exception report that they have submitted at any point in the process following submission. All exception reporting data, including those which have been withdrawn, will be retained for the GoSWH to allow them to perform their role in checking for potential safety implications.

Number of exception reports withdrawn over the last quarter	0

e) Access to individual doctors ’exception reporting data

Personally identifiable datarelated to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.

The affected doctor should be notified of this action as soon as practically possible, and the number of such disclosures must be presented in a manner that preserves a doctors' anonymity.

Number of exception reports disclosures over the last quarter	0

f) Work schedule reviews related to exception reporting pattern/instances

The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.

Number work schedules reviews related to exception reporting patterns or instances	Maxfax have locally been reviewing their work schedules under the surgical tutor.

g) Rota gaps on all shifts

Total number of rota gaps on all shifts over the last quarter	335

h) Additional information on an ad hoc basis

The GoSWH is required to report any escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level.

Details N/A
Free text

The GoSWH is required to report issues, with certain posts, that cannot be remedied locally and require a system-wide solution. The board is required to raise the system-wide issue with partner organisations (for example, NHS England) to find a solution.

Details N/A
Free text

NHS Employers

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2. Annual reporting requirements

The GoSWH quarterly report (including annual summary reports) will be standardised to a national template jointly produced in guidance to allow central data processing.

The recipients of annual summary reports are detailed in section 3 of this guidance.

a) Disbursement of fines

The details of the GoSWH fines will be published in the organisation's annual financial report (accounts), which are subject to independent audit. The GoSWH annual report will include clear detail on how the money has been spent. (Schedule 5 paragraph 31)

Annual financial report requirements

Fine	Number of fines applied	Value of fines applied
Additional hours worked breach	13 (4 were deanery trainees and 9 LED)	NB only deanery trainee fines pay into the Guardian fine pot the amount of which for Q2 was £476.98
Information breach	0	0

Access and completion breach	0	0
Missed breaks breach	0	0
Total	0	0

Annual report requirements

Details of how the fines money has been spent: We have not spent any fine money as we only recently got some back in the pot. Some of this Q2 money was allocated from Q1 reports.

b) Work schedule reviews relating to education and training

The DME shall report annually to the board on all work schedule reviews relating to education and training.

Number of work schedule reviews related to education and training	0

c) Rota gaps

A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the trust's quality account, which must be signed off by the trust's chief executive.

NHS Employers

Total number of rota gaps on all shifts over the last year	335

Count of Request Reason	Jul	Aug	Sep	Grand Total
Additional Activity - Theatre		3	10	13
Additional Clinic List - Sat/Sun	22	25	6	53
Additional Clinic List - Weekday	31	23	15	69
Additional Patient Admin		2		2
Annual Leave	4		1	5
Maternity		2		2
On Call	9	18	16	43
On Call - 2nd On Call cover			13	13
Other/Please state in the note	21	16		37
REGO Triage		3	19	22
Rota Gap - LTFT Trainee	5	5	10	20
Rota Gap - On Call Rota		2		2
Sickness	2	8	6	16
Special Leave	1			1
Study Leave	1			1
Training	7		1	8
Vacancies	8	13	7	28
Grand Total	111	120	104	335

NHS Employers

3. Recipients of board reports

All quarterly reports must be publicly accessible online within one month after the report has been created.

Information to be shared	Recipient(s) of board reports	Frequency
Quarterly reports	• This report must be sent directly to: • the Joint Local Negotiating Committee (JLNC) • the Local Negotiating Committee (LNC) chair • at least one nominated LNC resident doctor, and relevant RDF representatives upon completion. • DHSC/NHS England • NHS England (Local office), Care Quality Commission, General Medical Council and General Dental Council. • In addition, all quarterly reports must be publicly accessible online within one month after the report has been created.	Quarterly

Issues identified as a result of exception reporting that cannot be remedied locally and require a system-wide solution	LNC The board will raise the system-wide issue with partner organisations (eg NHS England) to find a solution.	Ad hoc
Annual reports	DHSC/NHS England local offices of NHS England, the Care Quality Commission, the General Medical Council and the General Dental Council.	Annual

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026		**Agenda reference:**	**101-26**	
Report title:	Freedom to Speak Up report				
Sponsor:	Jackie Doherty, Freedom to Speak Up Guardian				
Author:	Jackie Doherty, Freedom to Speak Up Guardian				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the Board with the biannual update on Freedom to Speak Up.				
Summary of key issues	This report presents the six monthly data of cases presented to the Freedom to Speak Up Guardian between 01 April - 30 September 2026. During this period there have been a total of 17 cases raised. There were no red cases, 2 were amber and 15 were ragged as green. All cases escalated by the Guardian were responded to in a timely manner by the Trust. The main themes of cases raised with The GSL in this reporting period were: management issues with 6 cases, worker safety/wellbeing, behaviour/relationships and system and process with 3 cases each. The concerns detailed in this report have been raised by a variety of job groups with the main ones being: • Admin and Clerical - 8, • Allied Health Professionals, Estates and Ancillary – 3 • Medical and Dental – 2 • Nursing – 1 The main reasons staff accessed The Guardian Service were because they had previously raised a concern, representing 53% of cases, the need for impartial support, representing 41%, and fear of reprisal, representing 6%. This suggests that the service continues to provide an important independent route for staff seeking advice, support, and confidence in speaking up.				
Recommendation:	The Board is asked to **note** this report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	**KSO2:** ***To innovate and improve***	**KSO3:** ***To be an excellent employer***	KSO4: *To deliver sustainable services*	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	Quality BAF				
Organisational risk register:	None				
Regulation:	CQC				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Leadership Team				
	Date:	19/11/2026	Decision:	Submit to Board	

Six Month Report

1st April – 30th September 2026

Queen Victoria Hospital

Distribution: Public Board

Main Point of Contact:

Liz Blackburn

Executive Lead for FTSU

Prepared by:

Jackie Doherty

Freedom to Speak Up Guardian

The Guardian Service Ltd.

Date:

12th October 2026

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1. Executive summary

This report presents the six monthly data of cases presented to the Freedom to Speak Up Guardian between 01 April - 30 September 2026.

During this period there have been a total of 17 cases raised. There were no red cases, 2 were amber and 15 were ragged as green. All cases escalated by the Guardian were responded to in a timely manner by the Trust.

Twelve cases were closed during the period. Of these, 11 concluded with either a written or verbal outcome, while one was closed following no further contact from the staff member. Eight closed cases resulted in staff members choosing to escalate their concerns directly after receiving support from the Guardian Service, demonstrating the role of the service in empowering staff to raise concerns through appropriate routes.

The main themes of cases raised with The GSL in this reporting period were: management issues with 6 cases, worker safety/wellbeing, behaviour/relationships and system and process with 3 cases each. Further information is available under the assessment of cases in this report.

The concerns detailed in this report have been raised by a variety of job groups with the main ones being, Admin and Clerical with a total of 8, Allied Health Professionals, Estates and Ancillary, with 3 concerns, Medical and Dental 2 and 1 raised from Nursing and Midwifery.

The main reasons staff accessed The Guardian Service were because they had previously raised a concern, representing 53% of cases, the need for impartial support, representing 41%, and fear of reprisal, representing 6%. This suggests that the service continues to provide an important independent route for staff seeking advice, support, and confidence in speaking up.

There are recommendations at the end of this report for the Board's consideration. These build on those made in the previous reporting period and are intended to support continued improvement in speaking up culture, organisational responsiveness, and learning from staff concerns.

2. Purpose of the paper

The purpose of this paper is to give an overview of the cases raised at QVH to the Freedom to The Guardian Service Limited (GSL) during the 6 month period of 2026. This reporting period begins on 1st April 2026 and ends on 30th September 2026

This paper does not include any data relating to cases raised internally and only those raised with the Guardian. This paper will not contain any identifiable information to ensure that confidentiality of those raising concerns is respected in line with national guidelines.

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3. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work related concerns. We work closely with the NHSE and attend relevant FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout QVH as an independent service. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the QVH Board to promote and comply with the national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in QVH on the 1st May 2024.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

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6. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Relates to patient safety/quality, safeguarding and care, staff safety /wellbeing, issues of potential danger to any individual including self-harm. Fraud.	Response required within 12 hours
Amber	Includes bullying, harassment, discrimination, inequality staff safety. Patient safety/quality, staff safety /wellbeing, and fraud can be considered in this category if there is no immediate threat.	Response required within 48 hours
Green	All other themes e.g. change in work conditions etc.	Response required within 72 hours
White	Matters with no discernible risk or cases that highlight opportunities for improvement.	No organisational response required

Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

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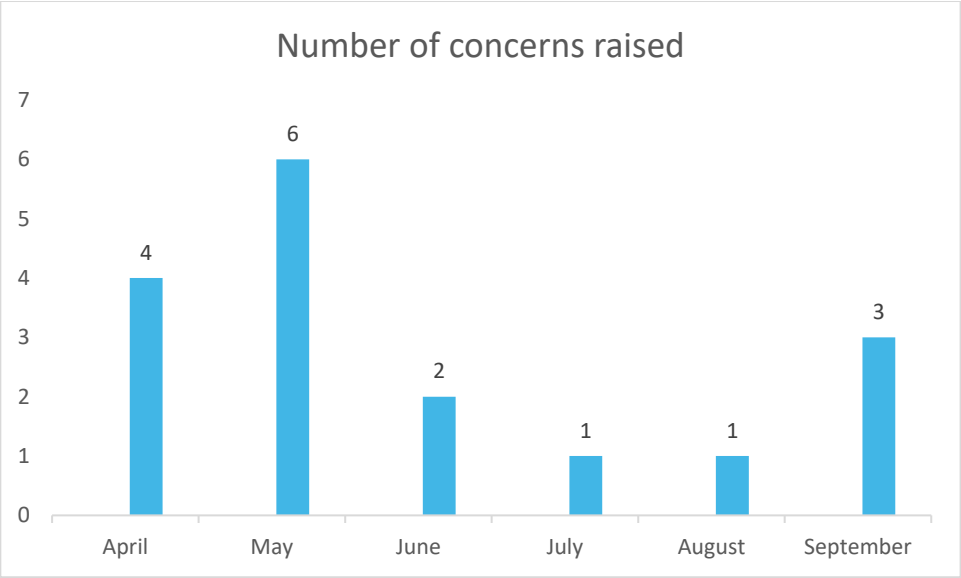
7. Number of concerns raised

There have been a steady number of concerns raised with a total of 17 in the reporting period 01 April-30 September 2026



8. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	14	82%
Permission to escalate with names	3	18%
Permission to escalate without name	0	0
Permission to escalate anonymously	0	0
Total	**17**	**100%**

9. Themes

Each case is recorded under a primary theme, with any additional themes logged as multi-theme occurrences. Quarterly national reporting is based on multi-theme occurrences, which reflect cases involving elements of more than one theme.

Concerns raised are broken down into the following categories;

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Primary Theme	Total
Patient Safety / Quality of Care	0
Worker Safety / Wellbeing	3
Bullying / Harassment	2
Behaviour / Relationship	3
Discrimination / Inequality	0
Management Issue	6
Sexual Misconduct	0
System / Process	3
Other (Describe)	0
Grand Total	**17**

Multi Theme-Occurances	Total
Patient Safety / Quality of Care	0
Worker Safety / Wellbeing	4
Bullying / Harassment	3
Behaviour / Relationship	8
Discrimination / Inequality	1
Management Issue	10
Sexual Misconduct	0
System / Process	5
Other (Describe)	0

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10. Trends in Cases

Average Cases per month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Average
April 24 to March 25	N/A	3	4	6	1	1	4	1	4	6	0	3	3
April 25 to March 26	3	4	1	2	4	2	3	4	2	5	4	2	3
April 26-Sept 26	4	6	2	1	1	3	N/A	N/A	N/A	N/A	N/A	N/A	3

The number of cases has remained consistent over the period GSL has been the independent provider of Freedom to Speak Up in QVH.

11. Assessment of Cases

The top theme during the period this report covers is Management Issues with 6 cases making up 35% of the total cases raised.

Examples of this have been feeling unsupported by managers, belief they are treated differently by management, and management speaking inappropriately and unkindly.

The theme of Worker Safety/Wellbeing had a total of 3 concerns, 18%, and examples of this are, what are believed to be unsafe working conditions and incivility from manager, affecting their wellbeing.

The theme of System/Process also had a total of 3 concerns raised,18%, and these were regarding the belief that correct processes were not being followed, or agreed timescales were not met.

There were also 3 concerns raised, 18%, under the theme of Behaviour/Relationships, these cases were regarding managing difficult staff members and behaviours from individual staff.

The other cases were regarding Bullying and Harassment and these were both regarding staff members feeling bullied by colleagues.

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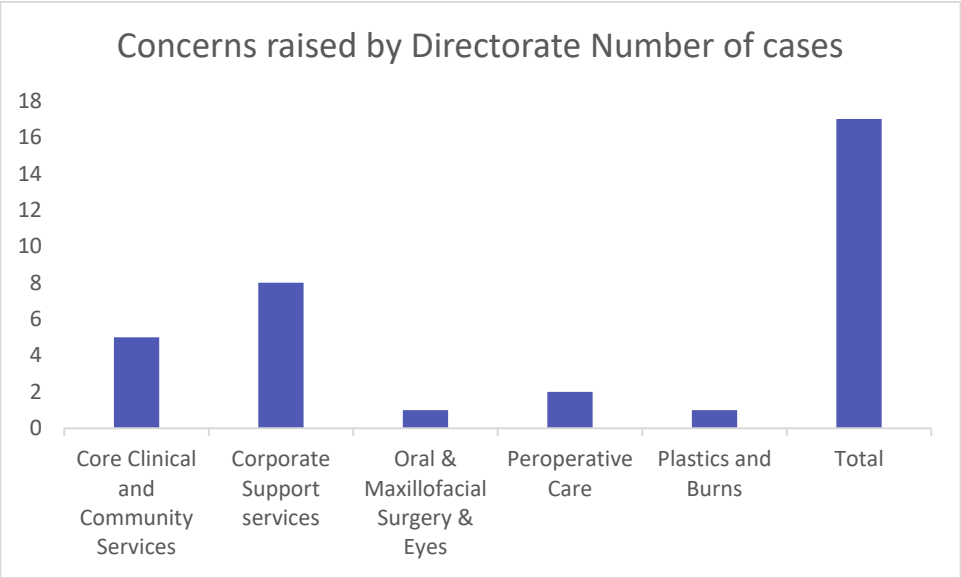
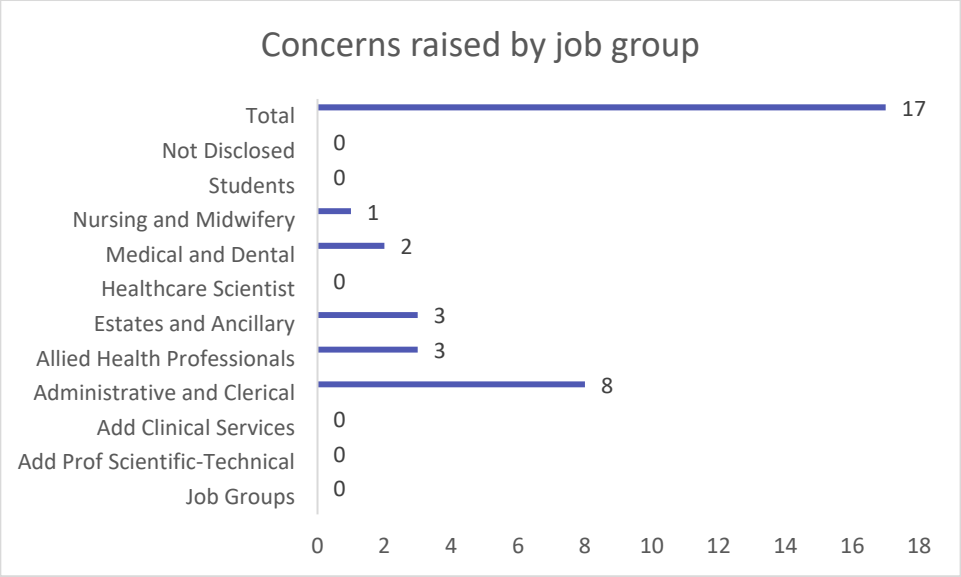
12. Statistical Graphs

Concerns raised by Directorate



Concerns raised by Job Group



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13. Why do staff use The Guardian Service?

Reason why staff use the Guardian Service	No. of concerns	Percentage
Impartial Support	7	41%
Fear of reprisal	1	6%
Believe they will not be listened to	0	0
Have raised concern before, but not been listened to	9	53%
Other	0	0
Total	**17**	**100%**

14. Detriment

There has been no reported detriment in this period. The Guardian Service encourages staff to speak up whilst maintaining that they will not suffer any detriment. The FTSU Guardian spends a great deal of time with staff members creating a psychologically safe space for them to be able to share their experiences openly, reassuring them that if they do feel they have suffered detriment they must report this to the FTSU Guardian immediately. This is part of the process and gives staff confidence they will continue to be supported. Detriment is a major concern that is associated with speaking up and has a huge influence on FTSU culture.

15. Action taken to improve the Freedom to Speak Up Culture

During the period the report covers, there has been regular promotions from FTSUG including drop-in sessions, walkarounds, staff handovers and attendance at team meetings, covering both clinical and non-clinical staff.

There is also the online booking system available for easy accessibility of the service, and a link to this can be found on the staff intranet.

Regular meetings are held with CEO, Executive and Non-executive directors for Freedom to Speak Up, and quarterly reports are given to the wider Executive Team.

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16. Learning and Improvements

There has been an increase in visibility of the Executive Team across all areas of the Trust, with a plan now in place to ensure this is happening. This will help workers to feel safe, valued, and confident to speak up and workers are likely to emulate the values and behaviours they see in their more senior colleagues.

Of the cases reported in this period, impartial support has been a reason why 47% have been raised to GSL, This illustrates that staff feel they need someone to talk to without necessarily taking any action. We could question why they feel the need to come to GSL rather than talk to managers, although this also illustrates the benefit of having an independent, confidential service.

There has also been an increase in the number of staff that, having spoken to the Guardian, have then escalated the concern themselves, and this shows the benefit of having an independent, confidential service available to all staff.

17. Comments & Recommendations

The main comments and recommendations are consistent with the last report presented in May 2026.

Support continued promotion of the Trust's Behaviour Framework in response to concerns relating to professional behaviours

Due to the number of staff who have used the service because they feel they have raised a concern before but not been listened to, ensure managers feel equipped and empowered to manage concerns effectively and maintain clear communication with staff throughout the process.

Support ongoing wellbeing and aftercare arrangements for staff involved in speaking up and for those who have been involved in formal investigation or resolution processes, ensuring appropriate support is available following the closure of a case.

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Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**102-26**		
Report title:	Annual Equalities Report 2025-26				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Sacha Campbell, Wellbeing and Inclusion Manager Lawrence Anderson, Deputy Chief People Officer				
Appendices:	None				
Executive summary					
Purpose of report:	Provide the Board with the Trusts' 2025–26 Annual Equalities Report ahead of publication on the Trusts' website.				
Summary of key issues	• QVH has established EDI governance, training and engagement initiatives, with ongoing work to enhance the quality and completeness of demographic data to better understand and address inequalities. • The Strategy and Culture Committee recognise there is further work to be done with the demographic data and the wider comparisons to public health data, with ongoing work being done over the coming year. • EDI champions, networks and cultural transformation initiatives are supporting a more inclusive environment, with further opportunities to strengthen confidence in reporting concerns and ensure all voices are heard. • Sustained progress in workforce inclusion: Inclusive recruitment, flexible working and workforce development programmes are delivering positive outcomes, with ongoing work focused on increasing representation, disclosure of protected characteristics and equitable experiences for all colleagues.				
Recommendation:	The Board is asked to **approve** the publication of the report on the Trusts' website.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:** **To deliver outstanding care**	KSO2: To innovate and improve	**KSO3:** **To be an excellent employer**	KSO4: To deliver sustainable services	KSO5: To collaborate with others
Implications					
Board assurance framework:	People BAF				
Corporate risk register:	N/A				
Regulation:	N/A				
Legal:	N/A				
Resources:	N/A				
Assurance route					
Previously considered by:	Strategy and Culture Committee				
	Date:	29/10/2026	Decision	Present report to Trust Board	
Next steps:	Subject to approval by the Board, publication of the annual report on the Trusts' website				

Annual Equalities Report
2025-26

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Foreword

"At Queen Victoria Hospital NHS Foundation Trust, we are committed to creating an environment where every patient, colleague, volunteer and visitor feels valued, respected and included. Equality, diversity and inclusion are fundamental to who we are as an organisation and are integral to achieving our vision of providing outstanding care and supporting our people to thrive.

This report highlights the continued progress we have made during 2025–26 in advancing equality of opportunity, fostering good relations and embedding inclusive practices across the Trust. We have strengthened our approach through a wide range of initiatives, including the development of our EDI Champions network, the establishment of the Cultural Transformation Steering Group, enhanced inclusive recruitment practices and continued investment in learning and development for our workforce. High levels of compliance with mandatory equality and inclusion training demonstrate the commitment of our colleagues to creating a respectful and compassionate culture.

We have also continued to improve our understanding of the diverse communities we serve and employ. While our data provides valuable insights, we recognise the opportunity to further enhance the quality and completeness of demographic information to better identify and address inequalities. This remains an important priority over the coming year as we continue our digital transformation journey and implement new systems and processes.

Importantly, this report reflects not only our achievements but also our commitment to continuous improvement. We know that creating an inclusive organisation requires ongoing listening, learning and action. Through our People and Culture Strategy, patient engagement and partnership working, we will continue to build a workplace and healthcare environment where everyone can belong, contribute and succeed.

I would like to thank all colleagues, volunteers, patients and partners who have contributed to this work over the past year. Your commitment to our values helps make QVH a more inclusive organisation every day. Together, we will continue to advance equality, celebrate diversity and ensure that everyone is treated with dignity, fairness and respect."

Helen Edmunds

Chief People Officer, Queen Victoria Hospital Foundation Trust

Executive Summary

Queen Victoria Hospital (QVH) is committed to meeting its duties under the Equality Act 2010 by eliminating discrimination, advancing equality of opportunity and fostering good relations for patients, staff and volunteers. This report covers April 2025 to March 2026 for our workforce data, and October 2025 to September 2026 for our service user data to provide the most accurate measure of demographics. Between October 2025 and September 2026, QVH provided care to 83,301 unique patients through over 241,000 appointments and attendances. The patient population is broadly balanced by gender, with most activity involving adults aged 25-79. While age and gender data are highly complete, gaps remain in the recording of ethnicity, religion and other demographic characteristics, limiting the Trust's ability to fully understand inequalities in access, experience and outcomes. These are areas to be reviewed and worked on over the next year.

As of 31 March 2026, QVH employed 1,261 staff and was supported by 59 volunteers. The workforce is diverse, with 25.0% of staff identifying as being from ethnic minority groups and 8.5% declaring a disability. The Trust continues to support inclusion through flexible working opportunities, apprenticeships, staff networks and targeted workforce development programmes.

Progress has continued in building equality, diversity and inclusion capability across the organisation. Compliance with mandatory Equality, Diversity and Human Rights training reached 94.8%, while 93.7% of colleagues completed the Oliver McGowan Disability and Autism e-learning programme. Additional training on neuro-inclusion, recruitment and selection, and inclusive leadership has further strengthened awareness and confidence in supporting diverse colleagues and patients.

QVH has continued to promote fair and inclusive recruitment through its Disability Confident commitments, reasonable adjustment processes and guaranteed interview scheme for disabled applicants. Equality considerations are also embedded in organisational decision-making through Equality Impact Assessments, with 118 assessments reviewed during 2025-26.

The Trust has strengthened its approach to inclusion through initiatives including the Armed Forces Network, EDI Champions Scheme, Cultural Transformation Steering Group and Additional Needs Group. These forums help amplify staff and patient voices, promote psychological safety and drive continuous improvement.

While the number of reported discriminatory or harassment incidents remains relatively low, staff survey findings suggest that some experiences may go unreported, reinforcing the need to maintain a culture where concerns can be raised safely and addressed appropriately.

Overall, QVH has made positive progress in advancing equality, diversity and inclusion during 2025-26. Priorities for the coming year include improving demographic data quality and using public health data to understand how representative the workforce and service uses are compared to the wider population, increasing representation and

disclosure across protected characteristics, strengthening confidence in reporting concerns and continuing to embed inclusive practices across all areas of the organisation.

Background

As an NHS Trust, QVH is legally required to promote equality in all that we do, both as an employer and as a service provider. Under the Public Sector Equality Duty of the Equality Act 2010, we have a duty to:

- Put an end to unlawful discrimination
- Advance equality of opportunity
- Foster good relations between different people.

To evidence how we are meeting these duties, we are required to publish equality information annually. This should include information that helps us to identify equality issues and information about the steps we have taken to meet our legal duties.

In addition to this report, we also publish our Gender and Ethnicity Pay Gap reports annually on our public website, as well as our Workforce Race Equality Standard and Workforce Disability Equality Standard reports.

This ensures that our staff, service users, regulators and members of the public can hold us to account for our performance around equalities.

This report covers April 2025 to March 2026 for our workforce data and October 2025 to September 2026 for our service user data, to provide the most accurate measure of demographics.

Service User Demographics

This analysis covers the 12-month period from 1 October 2025 to 30 September 2026 and provides the most up-to-date annual view of patient demographics for activity delivered at the QVH East Grinstead site. Activity delivered at QVH spoke sites is not included within this dataset. During this period, QVH recorded 23,650 admissions, 201,440 outpatient attendances and 16,086 Minor Injury Unit (MIU) attendances, involving 83,301 unique patients.

QVH holds highly complete data for age and gender, as these form part of the core demographic information routinely recorded for patients. Completeness is more variable across other protected characteristics and demographic fields, including ethnicity, marital status and religion or belief. The position for each characteristic is set out below. Gaps in demographic data continue to limit the Trust's ability to fully analyse variation in access, experience and outcomes between different population groups. Improving the quality and usability of demographic information therefore remains an important part of the Trust's health inequalities and digital work. Alongside this, it is recognised that further work will be undertaken over the next year to review public health data to understand more about the wider population and how representative our workforce and service uses are, what more could be done to make our services more accessible and whether there are gaps in groups not accessing services.

Methodology

- The analysis covers the 12-month period from 1 October 2025 to 30 September 2026.
- The dataset includes activity delivered at QVH East Grinstead site only and excludes activity delivered through spoke-site services.
- Activity data includes admissions, outpatient attendances and MIU attendances.
- The patient population comprises 83,301 unique patients during the reporting period.
- Age is reported using activity-level data, as a patient's age may change during the reporting period and this provides the most accurate reflection of service use by age.
- For the other demographic characteristics, analysis is based on unique patients to provide a picture of the patient population rather than total activity.
- Where demographic characteristics are not available as structured fields, or recording completeness is limited, this is identified within the relevant section and should be considered when interpreting the findings.

Age at Appointment (All Appointments):

Age Band	Count of Activity	%
0-17	28049	11.6%
18-24	14143	5.9%
25-59	89725	37.2%
60-79	74757	31.0%
80-99	34368	14.3%
100+	134	0.1%
Grand Total	**241176**	100.0%

Adults aged 25–59 account for the largest share of appointments at 37.2%, followed by those aged 60–79 at 31.0%. Children and young people aged 0–17 represent 11.6% of appointments, while patients aged 80–99 account for 14.3%. Patients aged 18–24 make up 5.9%, with those aged 100 and over representing a very small proportion of activity at 0.1%.

Sex (Unique Patients)

Sex	Count	%
M	41913	50.3%
F	41362	49.7%
I	25	0.03%
(blank)	3	0.004%
Grand Total	**83303**	**100%**

The unique patient population is almost evenly split between female and male patients, with very small numbers recorded as intersex or blank.

Ethnicity (Unique Patients)

Ethnicity	Count	%
WHITE - BRITISH	59158	71.0%
WHITE - IRISH	537	0.6%
WHITE-ANY OTHER BACKGROUND	3024	3.6%
ASIAN/ASIAN BRITISH INDIAN	1163	1.4%
ASIAN/ASIAN BRITISH-PAKISTANI	358	0.4%
ASIAN/ASIANBRIT BANGLADESHI	219	0.3%
BLACK/ BLACK BRITISH-AFRICAN	778	0.9%
BLACK/BLACK BRITISH-CARIBBEAN	375	0.5%
GYPSY OR IRISH TRAVELLER	49	0.1%
MIXED-WHITE & BLACK AFRICAN	202	0.2%
MIXED-WHITE AND ASIAN	349	0.4%
MIXED-WHITE&BLACK CARIBBEAN	256	0.3%
ANY OTHER BLACK/BLACK BRITISH	173	0.2%
ANY OTHER ASIAN/ASIAN BRITISH	567	0.7%
ANY OTHER ETHNIC GROUP	568	0.7%
ANY OTHER MIXED BACKGROUND	400	0.5%
OTHER ETHNIC GROUP-CHINESE	317	0.4%
NOT STATED PATIENT DECLINED	2703	3.2%
NOT YET COLLECTED	12117	14.5%
Grand Total	**83313**	**100.0%**

Around three quarters of unique patients are recorded as White (75.2%). 14.5% have no ethnicity recorded, with a further 3.2% recorded as not stated because the patient declined to provide this information. Asian or Asian British patients account for 2.8%, Black or Black British patients 1.6%, Mixed ethnicity patients 1.4%, and other ethnic groups around 1.1%.

Marital Status (Unique Patients)

Marital Status	Count	%
CO-HABITEE	1397	1.7%
DIVORCED	786	0.9%
MARRIED	10336	12.4%
SEPARATED	213	0.3%
SINGLE	11901	14.3%
UNKNOWN	57621	69.2%
CIVIL PART	36	0.0%
WIDOWED	1016	1.2%
Grand Total	**83307**	**100.0%**

Marital status is recorded for about one third of patients, with the majority listed as Unknown.

Indices of Multiple Deprivation (IMD) Unique Patients

IMD Decile	Count	%
1	1668	2.0%
2	2818	3.4%
3	4014	4.8%
4	6795	8.2%
5	7950	9.5%
6	8410	10.1%
7	10886	13.1%
8	10064	12.1%
9	15004	18.0%
10	14401	17.3%
(blank)	1291	1.5%
Grand Total	**83301**	**100.0%**

IMD is a national measure of relative deprivation that ranks areas in England from 1 (most deprived) to 10 (most affluent), based on factors such as income, employment, health, education, housing and crime. Just over a third of unique patients at QVH come from the most affluent areas, with 35.3% living in IMD deciles 9–10. 5.4% are from the most deprived areas, IMD deciles 1–2. Around 57.8% are from the middle bands, IMD deciles 3–8, while deprivation data is unavailable for 1.5% of patients.

Religion and Belief (Unique Patients)

Religion	Count	%
AGNOSTIC	36	0.04%
ANGLICAN	33	0.04%
ATHEIST	134	0.16%
BAHA'I FAITH	3	0.00%
BAPTIST	45	0.05%
BUDDHIST	46	0.06%
CHRISTIAN	2517	3.02%
CHURCH OF ENGLAND	5555	6.67%
CHURCH OF IRELAND	6	0.01%
CHURCH OF SCOTLAND	26	0.03%
CONGREGAT	11	0.01%
FREE CHURCH	8	0.01%
GREEK ORTHODOX	27	0.03%
HINDU	191	0.23%
ISLAM	126	0.15%
JAINISM	3	0.00%
JEHOVAH WITNESS	47	0.06%
JEWISH	47	0.06%
METHODIST	84	0.10%

MORMON	11	0.01%
MUSLIM	285	0.34%
NO RELIGION	1409	1.69%
NON CONFORM	8	0.01%
NONE	9778	11.74%
NOT STATED	946	1.14%
OTHER RELIGION	189	0.23%
PROTESTANT	20	0.02%
QUAKER	2	0.00%
ROMAN CATHOLIC	1416	1.70%
SALVATION ARMY	3	0.00%
SIKH	71	0.09%
SPIRITUALIST	34	0.04%
UNITED REFORMED	16	0.02%
UNKNOWN	60181	72.23%
Grand Total	**83314**	**100.00%**

Unknown accounts for 72.2% of records. Among recorded values, Christian denominations combined account for around 11.7%**,** while categories indicating no religion, including None, No Religion, Atheist and Agnostic account for around 13.6%**.** Individual non-Christian faith groups each account for less than 1% of the total patient population.

Staff Protected Characteristics

We had 1,261 staff members on 31 March 2026. Of those:

- 73.3% of staff are 31-60 years old, with 12.9% aged 30 and under and 13.9% aged 61 and over
- 8.5% have declared that they have at least one disability and 2.1% have not provided an answer
- Of those that have told us they have a disability, 33.3% have a learning disability or difficulty, 27.4% have a long-standing illness, 12.8% have a mental health condition, 13.6% have a physical impairment, 7.7% have a sensory impairment and 12.0% have a disability that does not fit into one of these categories.
- 74.6% are white, 25.0% are from ethnic minority groups and 0.4% have not responded
- 68.0% are religious, with 17.8% saying they are not religious and 14.3% not providing an answer
- 74.7% are female and 25.3% are male (the Electronic Staff Record system only allows these 2 options)
- 85.7% are heterosexual or straight, with 3.6% gay, lesbian, bisexual or another sexual orientation, and 10.7% not providing an answer
- 13 Armed Forces community roles have been declared
- 12 staff have told us they are working carers.

Volunteer Protected Characteristics

On 31 March 2026, QVH had 59 listed volunteers. Of those:

- 27% are aged 36-60 years old, with none aged 35 and under and 73% aged 61 and over
- 5% have declared that they have at least one disability and 17% have not provided an answer
- Of those that have told us they have a disability, 67% have a learning disability or difficulty and 33% have a physical impairment
- 88% are white, 2% are from ethnic minority groups and 10% have not disclosed their ethnicity
- 59% are religious, with 12% saying they are not religious and 29% not providing an answer
- 81% are female and 19% are male (the Electronic Staff Record system only allows these 2 options)
- 71% are heterosexual or straight, with 2% gay, lesbian, bisexual or another sexual orientation, and 27% not providing an answer.

Equality, Diversity and Inclusion Training

Mandatory Training

All staff undertake mandatory training in Equality, Diversity, and Human Rights to meet the national UK Core Skills Training Framework, which is renewed every three years.

As of 31 March 2026, 94.8% of our colleagues were up to date with this training:

Staff group	Headcount	Compliant	Compliant %
Add Prof Scientific and Technic	35	32	91.4%
Additional Clinical Services	162	156	96.3%
Administrative and Clerical	373	350	93.8%
Allied Health Professionals	98	96	98.0%
Estates and Ancillary	65	64	98.5%
Healthcare Scientists	42	38	90.5%
Medical and Dental	195	183	93.8%
Nursing and Midwifery Registered	235	224	95.3%
Students	15	14	93.3%

Oliver McGowan Tier 1 E-Learning

During 2025-26, the Trust continued to support the roll out of the Oliver McGowan Mandatory Training on Learning Disability and Autism, strengthening colleagues' understanding of learning disability, autism, communication needs and reasonable adjustments. By 31 March 2026, 93.7% of QVH colleagues had completed the e-learning module.

The additional Tiers 1 and 2 of the Oliver McGowan training rolled out from April 2026, with a projected compliance rate of >30%, a target set by Surrey and Sussex ICB. QVH are currently ahead of the projected compliance.

Apprenticeships

Apprenticeships continue to play an important role in supporting workforce diversity at QVH. Our apprentice population reflects a broad range of backgrounds and experiences, helping to widen participation and create opportunities for career development across underrepresented groups:

- 71.0% are aged over 25, 22.6% are aged 21-25 and 3.2% are aged under 20 years old
- 11.3% have told us that they have a disability, and 1.6% have not provided an answer
- 10.9% are from ethnic minority groups
- 82.3% are female

Line Manager Training

In 2025, QVH launched the pilot of its Managers' Essentials Programme with the aim to develop line manager capability and confidence in managing people. This includes training on equality, diversity and inclusion principles throughout the employee lifecycle, inclusion in an NHS context and managing requests for reasonable adjustments.

As of 31 March 2026, 27 managers had completed the programme. Attendees rated their understanding of EDI principles and their confidence in embedding them within their teams at an average score of 4.4/5.

Recruitment and Selection Training

All recruitment and selection panels must include at least one member that has attended the Trust's recruitment and selection training and be able to advise the rest of the panel of the process.

The training is delivered by the Trust's Resourcing team and covers best practice in recruitment and selection, including requirements under the Equality Act 2010, our duties as a Disability Confident Employer, unconscious bias, offering reasonable adjustments and promoting equality of opportunity.

In 2025-26, the team delivered this training to 22 employees, including new starters and those requiring refresher training.

Neuro-inclusion Training

In 2026, the Trust offered Neuro-inclusion training delivered by lived experience trainers, with the aim to give staff a comprehensive understanding of neurodiversity. This training was completed by 63 QVH colleagues.

This included key terms and common neurotypes, and recognising how these may present in the workplace.

Delegates were also trained on how to challenge behaviours that hinder neuroinclusion as well as learning more about the lived experiences of neurodivergent individuals.

Networks

Armed Forces Network

QVH's growing Armed Forces Network provides a forum to advocate for the interests of the Armed Forces Community.

In addition to our Armed Forces Network, QVH has signed the Armed Forces Covenant and achieved a Silver Award from the Ministry of Defence Employer Recognition Scheme in 2026. QVH is involved with the Step Into Health scheme, which helps to connect members of the Armed Forces community with NHS organisations.

EDI Champions

In 2025, QVH launched its EDI Champions scheme. Six staff took up this voluntary role, contributing to accessibility initiatives for staff, patients and visitors.

Our EDI Champions sit as members of the Cultural Transformation Steering Group and act as amplifiers for staff and patient voice, advocating for inclusive practices and driving local change.

Cultural Transformation Steering Group

The Cultural Transformation Steering Group was created in 2025 with the aim to lead, guide and keep track of the cultural changes happening within our organisation.

The group helps to ensure that the Trust stays on track with actions that promote a more inclusive and culturally aware workplace. To support this, the group is sponsored by our Managing Director and Chief Medical Officer and attended by colleagues in our Workforce, Organisational Development & Learning, Communications and Continuous Improvement teams as well as our EDI Champions. The groups' current focus is building psychological safety across the Trust.

Additional Needs Group

The Trust's Additional Needs Group provides leadership and direction to improve the delivery of care to patients with additional needs by working in partnership with patients, the public and QVH's workforce.

The Additional Needs Group work with QVH colleagues to review patient pathways and identify areas for improvement as well as having oversight of key programmes of work relating to any additional need.

Interpreting

Throughout 2025-26, Queen Victoria Hospital utilised interpreting services to support patients across both inpatient and outpatient settings.

These services, delivered through a combination of face-to-face and telephone interpreting, ensured effective communication and equitable access to care for patients with language needs.

Inclusive Recruitment

QVH is a Level 2 Disability Confident Employer. To support inclusive recruitment, QVH's Resourcing team offers training that covers best practice during recruitment and selection. This includes inclusive approaches, reasonable adjustments and fair decision-making, reflecting the Trust's commitment to equality, diversity and inclusion.

To support inclusive recruitment, the Resourcing team have developed guidance notes for applicants that include how to complete the application form and how to request reasonable adjustments. A manager's guide has also been produced, detailing how recruiting managers and selection panel members can accommodate requests for reasonable adjustments.

Guaranteed Interview Schemes

During 2025-26, 192 candidates stated that they have a disability in their application on the TRAC recruitment system, representing approximately 5% of all applications.

68% (130) of disabled applicants opted in to the guaranteed interview scheme as part of their application. Of those:

- 35% (45) were shortlisted for interview
- 8% (10) were successfully appointed.

Discriminatory Incidents

Staff are able to report incidents of discrimination and harassment on the Trust's incident management system, Datix.

In 2025-26, 7 reports of discrimination and harassment based on protected characteristics were made via this system. 6 were related to race, and 1 was related to both race and sex. 6 of these incidents were abuse towards staff from service users, and 1 involved abuse towards staff from another colleague.

In addition, 3 reports of discrimination and harassment from staff, toward staff were made under Workforce policies, with 2 relating to disability and 1 relating to age, gender and ethnicity.

It is anticipated that discriminatory incidents are under-reported via formal Trust channels, as the 2025 NHS Staff Survey tells us that 5% (36) of staff experienced discrimination from patients, relatives and other members of the public, and 7% (46) experienced the same from managers and/or team members. NHS Staff Survey data indicates that over half of staff (56%) who experienced harassment, bullying, or abuse at work from any source went on to report it. Further work is being undertaken to promote psychological safety so that our staff feel able to report incidents.

Advancing Equality, Diversity and Inclusion at QVH

In 2025, QVH published its 2025-2030 People and Culture Strategy, which sets out our vision, values and objectives and actions to tackle inequalities, foster good relations and advance equality of opportunity for our diverse workforce.

This was developed through engagement with patients, carers and staff as well as data and insights about our staff, our local area and our patients to ensure that it reflects the needs of our workforce and our community.

QVH's Core Behaviours Framework, developed through engagement and workshops with a large number of staff and published in 2024, details how we put our values into practice. This sets out how we do things, what we say and how we say it, how we treat others and how we expect to be treated.

To support the implementation of the framework, a series of 1-hour workshops were offered to provide an understanding of how to apply and embed the framework into different areas of responsibility.

We also regularly assess our performance against EDI indicators.

Policies

The Trust's updated Equality, Diversity and Inclusion Policy was ratified and published in October 2025. This policy helps the Trust respond to discrimination by setting clear expectations and processes that promote fairness, dignity, and respect for all individuals.

It outlines legal obligations under the Equality Act 2010 and the Public Sector Equality Duty, ensuring that unlawful discrimination, harassment, and victimisation are actively prevented and addressed.

The policy provides practical guidance for reporting concerns and emphasises restorative approaches to resolve issues and protect affected individuals. The policy works in conjunction with our workforce policies and is aligned to the Trust's People and Culture Strategy 2025-2030.

Flexible Working

In 2025-26, 181 formal requests for flexible working were active. Of these, 89% were approved. This does not account for informal arrangements, such as local agreements for remote working or ad hoc requests to change working patterns. This also does not capture team-level flexible working options, such as self-rostering or flexitime.

Of these:

- 77% were submitted by female staff
- 17% were submitted by colleagues from ethnic minority groups
- 6% were submitted by those with a disability
- 1% was submitted by a colleague who declared themselves as a working carer
- 1% was submitted by colleagues from the Armed Forces community.

Equality Impact Assessments

Under the Public Sector Equality Duty 2011, we have a duty to eliminate discrimination, advance equality of opportunity and foster positive relationships. The duty also encourages public bodies to deliver better and safer services by understanding the needs of the communities it serves. At QVH, we evidence this by completing Equality Impact Assessments (EIAs).

All QVH policies and projects must consider if and to what extent they will impact equalities for our patients and staff and document any evidence of this. Where any negative impacts are identified, the project lead must document the actions they will take to minimise that impact, or justify why they cannot. Project leads must also document the evidence and engagement they used to inform their assessment.

EIAs are reviewed and signed off by a group of staff assessors with an interest in equalities. In 2025-26, 118 EIAs were submitted to the EIA assessors, including 98 policies, 6 clinical documents, 10 change projects and 4 rejected flexible working requests.

Acknowledgements

We remain thankful to colleagues across QVH who have been supporting our value of being compassionate and inclusive over all else, whether this is through promoting EDI activities, championing improvements in their local areas or advocating for more inclusive patient care.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**103-26**		
Report title:	Biannual assessment of addressing Health Inequalities				
Sponsor:	Liz Blackburn, Acting Chief Nursing Officer				
Author:	Ellie Winter, Strategy Programme Manager				
Appendices:	None				
Executive summary					
Purpose of report:	To provide the Trust Board with an update on progress against the Trust's 2026/27 Health Inequalities priorities.				
Summary of key issues	• H1 2026/27 has focused on moving from baseline measurement into targeted action across the four Health Inequalities priorities: access, data and digital capability, workforce capability, and additional needs. • Health inequalities metrics are now embedded within the IQPR, supporting more targeted work on deprivation, DNA variation and pathway access; ethnicity data completeness remains broadly stable at around 84–85% and below the 95% ambition. • Significant progress has been made on the Health Inequalities learning resource, with participant recruitment underway and interviews scheduled from mid-October into November using an Experience-Based Co-Design approach. • Practical improvements for patients with additional needs have continued, including accessible information, Butterfly Scheme activity, reasonable adjustment and PAS design work, and development of wayfinding and neurodiversity-friendly resources.				
Recommendation:	The Board is asked to **note** the content of this report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	KSO3:	KSO4:	KSO5:
	To deliver outstanding care	*To innovate and improve*	*To be an excellent employer*	*To deliver sustainable services*	*To collaborate with others*
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	None				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality & safety committee				
	Date:	03.11.2026	Decision:	Submit to Board	
Next steps:					

Biannual assessment of addressing Health Inequalities

Executive Summary

During the first six months of 2026/27, the Trust has continued to progress delivery of its Health Inequalities Programme across four priority areas: reducing inequalities in access to care; strengthening data quality and digital capability; building workforce capability; and improving access for patients with additional needs.

Progress during H1 has increasingly focused on moving from measurement and baseline analysis into targeted improvement activity. This has included the introduction of health inequalities metrics within the IQPR, further analysis of variation by deprivation and ethnicity, targeted work to reduce DNA rates and improve pathway access, and development of digital solutions to support more consistent recording of patient needs and reasonable adjustments.

Ethnicity data completeness has remained broadly stable at around 84–85% and remains below the Trust's 95% ambition. Improvement activity has therefore become more targeted, with particular focus on high-volume outpatient services including Plastics, OMFS and Therapies, alongside work to strengthen ownership, standardise data capture processes and improve staff guidance and communications.

Significant progress has also been made in developing the Trust's workforce capability offer. The Experience-Based Co-Design Health Inequalities Learning Resource project has moved from approval and planning into active mobilisation, with participant recruitment underway and interviews scheduled from mid-October into November. In parallel, practical improvements for patients with additional needs have continued, including accessible information developments, reasonable adjustment work, PAS design input and site navigation improvements.

Overall, the programme remains focused on translating insight into practical service improvement, with further work required during H2 to demonstrate measurable impact, particularly in relation to ethnicity data completeness and access variation.

Background

QVH's Health Inequalities Programme supports the Trust's statutory and strategic commitment to reducing inequity in access, experience and outcomes for patients and staff. The programme is aligned with the QVH Strategy 2025–2030 and Health Inequalities Strategy and reflects wider NHS and system priorities relating to prevention, population health, inclusion and equitable access to care.

For 2026/27, the Health Inequalities Steering Group agreed four priority areas:

1. Reduce inequalities in access to care
2. Strengthen data quality and digital capability
3. Build workforce capability
4. Improve access for patients with additional needs

These priorities were designed to build on the progress made during 2025/26, with a stronger focus on using data and patient insight to identify variation, target improvement activity and strengthen organisational capability. Progress is monitored through the Health Inequalities Steering Group, with assurance provided through the Executive Committee for Quality and Risk. Health inequalities metrics have also been incorporated into the Trust's Integrated Quality and Performance Report to support routine oversight of variation and improvement activity.

This paper provides a mid-year assessment of progress against the four 2026/27 priorities and identifies the key areas of focus for the remainder of the financial year.

Progress against 2026/27 priorities

1. Reduce inequalities in access to care
Good progress has been made against the Trust's 2026/27 priorities to improve equitable access to care and strengthen pathway management. Development of the Unified Pathway Manager (UPM) continues, including the mapping of Index of Multiple Deprivation (IMD) deciles to the Referral to Treatment (RTT) Patient Treatment List (PTL), which will provide greater insight into health inequalities and enable more targeted interventions. A dedicated UPM patient cohort is also being established to identify patients from more deprived communities who have repeatedly DNA'd or cancelled appointments, allowing proactive engagement to understand barriers to attendance and implement appropriate support across both RTT and non-RTT pathways. The Kent and Medway spoke-site DNA reduction project remains on track for completion by December 2026 and is expected to improve attendance rates, patient access and clinic utilisation. In addition, the consultant review process has been fully embedded through a formal Standard Operating Procedure, strengthening pathway governance, consistency and clinical oversight.

Over the coming months, the key focus will be on reducing treatment delays for patients living in areas of higher deprivation, where data continues to demonstrate poorer access and longer waits, alongside further reducing DNA and cancellation rates to support improved patient outcomes, service efficiency and equitable access to care.

2. Strengthen data quality and digital capability
Progress during H1 has focused on both improving the quality of health inequalities data and ensuring that future digital systems support more consistent recording of protected characteristics, patient needs and reasonable adjustments.

Ethnicity data completeness has remained broadly stable throughout the first half of the year at around 84–85%, below the Trust's 95% ambition. The Month 1 position was 84.74%, rising slightly during the year before returning to 84.6% in Month 5. The largest gaps continue to be concentrated within high-volume outpatient services, particularly Plastics, OMFS and Therapies.

While the overall metric has not materially improved during the first half of the financial year, engagement activity has continued, including distribution of staff guidance and patient information and reinforcement of ethnicity capture within routine admission and outpatient processes. During H2, the focus will shift to more targeted service-level improvement plans, using clinic-level data to identify areas of frequent non-capture and the points in the pathway where ethnicity information is most often lost or not recorded. A recent fix to the Power BI dashboard now enables General Managers to view ethnicity completeness at clinic-code level, providing a stronger basis for targeted action, clearer ownership and ongoing monitoring.

Digital capability work has progressed alongside this. The programme has contributed to PAS design discussions on mandatory protected characteristic fields and reasonable adjustments, reviewed options for migration and management of existing patient needs information and presented recommendations to the PAS Programme Board. Work has also included consideration of veteran status and participation in national discussions on sexual orientation data collection.

The H2 focus will remain on targeted ethnicity improvement, standardising capture processes in the highest-volume services, and ensuring the future PAS and related systems provide a stronger digital foundation for recording and using health inequalities data.

3. Build workforce capability
Substantial progress has been made during H1 in developing the Trust's approach to workforce capability on health inequalities. Following Executive Leadership Team approval, QVH has progressed an Experience-Based Co-Design project to create a Health Inequalities learning resource for staff, grounded in the lived experience of patients, community partners and QVH staff.

The project is designed to strengthen staff understanding of how health inequalities affect access, experience and outcomes of care, and to support staff to recognise what they can do differently within their own roles. A proportionate EBCD methodology is being used, including recorded interviews, separate staff and patient/VCSE workshops, and a joint co-design event, with the final content and format shaped by participants rather than predetermined.

Significant preparatory work has been completed during H1, including the project brief, participant criteria, governance arrangements, budget, communications and recruitment materials, information packs, reimbursement arrangements and a revised delivery schedule. Funding has been secured and recruitment is progressing. At the time of reporting, three QVH staff members and two VCSE representatives are confirmed, with two potential patient participants identified and further discussions underway. Interviews are scheduled from mid-October into November, followed by separate staff and patient/VCSE events and a joint co-design workshop.

The next phase will focus on completing recruitment, undertaking lived-experience and staff interviews, identifying key themes, and moving into facilitated co-design during Q3. The final resource will be designed for use across staff groups and will provide a reusable, practical way of translating health inequalities strategy into day-to-day learning and reflection.

4. Improve access for patients with additional needs

Work during H1 has continued to focus on practical changes that make services more accessible for patients with additional needs, alongside strengthening how those needs are identified and recorded. Progress has included the introduction of audio leaflets in the Corneo-plastics outpatients, wider use of the Butterfly Scheme, inclusion of Butterfly Scheme awareness within Clinical support worker (CSW) training, dementia-friendly environmental improvements within C-Wing and activity to promote awareness through Additional Needs Day. The first seven audio leaflets were made available to patients during H1.

Further work has focused on strengthening staff access to information and improving the patient journey. A staff directory on recording and supporting additional needs has been developed and is being prepared for wider feedback, while a dedicated working group has been established to review site wayfinding and maps. A proposal for neurodiversity-friendly patient resources is also being trialled within the Corneo-plastics department, with wider governance and applicability under review.

The Additional Needs Group has also continued to provide input into PAS design to make recording of additional needs and reasonable adjustments as straightforward and visible as possible. This remains an important dependency given the revised PAS timetable.

During H2, the focus will be on finalising and disseminating the staff directory, progressing the site wayfinding work, evaluating the neurodiversity-friendly resources, and continuing to influence PAS design so that additional needs and reasonable adjustments are consistently recorded and available to staff.

Recommendation

The Trust Board is asked to:

- **Note** the progress made against the Trust's 2026/27 Health Inequalities priorities

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**104-26**		
Report title:	NHS National Inpatient Survey 2025				
Sponsor:	Liz Blackburn, Acting Chief Nursing Officer				
Author:	Liz Blackburn, Acting Chief Nursing Officer				
Appendices:	Appendix one – QVH NHS Adult Inpatient Survey 2025 Benchmark Report				
Executive summary					
Purpose of report:	To provide an overview of the results of the NHS National Inpatient Survey 2025.				
Summary of key issues	The findings from the NHS Adult Inpatient Survey 2025 Benchmark Report provide strong assurance of the high quality of care delivered by Queen Victoria Hospital NHS Foundation Trust. The Trust achieved 42 questions rated as better or much better than expected compared to other NHS trusts, with no areas performing worse than expected. Patients reported particularly positive experiences in relation to kindness and compassion, respect and dignity, confidence in clinical staff, discharge planning and overall experience of care. Whilst performance remains significantly above national averages, the survey identified a small number of areas for continued focus. These include ensuring patients' cultural needs are consistently recognised and addressed, reducing sleep disruption associated with room temperature, strengthening communication between clinicians and patients, and enhancing discharge planning, particularly discussions regarding home adaptations and post-discharge support.				
Recommendation:	Trust Board is asked to note the results of the NHS Adult Inpatient Survey.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	KSO2:	KSO3:	KSO4:	KSO5:
	To deliver outstanding care	*To innovate and improve*	*To be an excellent employer*	*To deliver sustainable services*	*To collaborate with others*
Implications					
Board assurance framework:	BAF – Quality and Safety				
Organisational risk register:	None				
Regulation:	CQC				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Executive Leadership team Quality & safety committee				
	Date:	03/11/2026	Decision:	Submit to Board	
Next steps:					

NHS National Inpatient Survey 2025

Introduction

The NHS Adult Inpatient Survey is commissioned annually by the Care Quality Commission (CQC) as part of the NHS Patient Survey Programme to assess patients' experiences of hospital care and identify opportunities for service improvement. The survey measures key aspects of the inpatient journey, including communication, involvement in care, discharge planning, dignity and respect, and overall experience.

Executive summary

The 2025 Adult Inpatient Survey demonstrates a very positive patient experience at Queen Victoria Hospital NHS Foundation Trust (QVH), with the Trust performing as one of the top two highest-rated organisations nationally across multiple domains of care. The survey received 499 responses from 1,250 patients invited to participate, achieving a response rate of 46%, above the national average of 38%.

Overall performance was highly favourable, with the Trust scoring significantly above expected levels on 42 survey questions and recording no questions that were rated worse than expected compared with other NHS trusts. Thirty-two questions were categorised as "much better than expected" and a further ten as "better than expected". Compared with the previous year's survey, 37 measures showed no statistical change and only four measures showed a statistically significant decline.

Background

The NHS Adult Inpatient Survey 2025 Benchmark Report presents the experiences of patients who received inpatient care at QVH. The survey forms part of the national NHS Patient Survey Programme and is used to assess the quality of care from the patient perspective and support continuous service improvement across NHS organisations.

The survey was conducted by the Survey Coordination Centre at Picker Institute and included patients aged 16 years and over who spent at least one night in hospital and were discharged during November 2025. A total of 160,829 patients were invited to participate in the survey across 130 acute and specialist NHS Trusts.

Assessment

The results demonstrate an exceptionally strong patient experience across the Trust, with performance significantly exceeding national benchmarks in almost every domain measured. The Trust achieved 42 questions rated better or much better than expected, with no questions rated worse than expected, placing it amongst the highest-performing NHS Trusts nationally.

Key strengths and areas of excellence:

- Patients reported exceptionally positive experiences of kindness, compassion, dignity and respect, with scores of 9.7/10 and 9.8/10 respectively, reflecting the Trust's strong caring culture and commitment to delivering compassionate care.

- Patients also expressed very high levels of confidence and trust in both doctors and nurses, with scores of 9.7/10, highlighting the strength of clinical relationships and the professionalism of staff across the organisation.

- Performance in meeting patients' basic care needs remained a particular strength, with outstanding results relating to hydration, nutrition, medication

management and personal care. These findings provide assurance that patients' fundamental needs are being met to a consistently high standard throughout their inpatient stay.

- The discharge experience was also highly rated, with patients reporting that they felt well informed about ongoing care and next steps following discharge. This reflects effective communication and discharge planning processes that support a safe transition from hospital to home.

- Overall, patients rated their inpatient experience at 9.3/10, placing the Trust amongst the highest-performing organisations within its regional comparator group and reinforcing the Trust's reputation for delivering high-quality care and an excellent patient experience.

Areas of focus and improvement:
While no areas were rated worse than expected nationally, the survey highlights several opportunities for improvement:

- Supporting patients with cultural and individual needs
- Ensuring consistent patient inclusion during clinical decision making
- Maintaining privacy at all times
- Monitoring environmental factors affecting patient sleep and room temperature

The 2025 Adult Inpatient Survey presents a highly positive picture of patient experience at QVH. The Trust continues to be recognised as a high-performing organisation, delivering care characterised by compassion, dignity, effective communication and strong clinical confidence.

Future improvement efforts should focus on sustaining these exceptional standards whilst addressing emerging trends relating to responsiveness to patient needs, communication and privacy concerns. Overall, the findings provide strong assurance that patients continue to receive care of an exceptionally high standard across the Trust.

Recommendation
The Board is asked to **NOTE** the results of the NHS Adult Inpatient Survey.



NHS Adult Inpatient Survey 2025 Benchmark Report

Queen Victoria Hospital NHS Foundation Trust

Care Quality Commission

Survey Coordination Centre

NHS

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6. Comparison to other trusts

- Comparison to other trusts

This work was carried out in accordance with the requirements of the international standard for organisations conducting social research (accreditation to ISO27001:2013; certificate number GB10/80275).

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Background and methodology

This section includes:

- an introduction to the NHS Patient Survey Programme
- information on the 2025 Adult Inpatient Survey
- a description of key terms used in this report
- guidance on how to navigate the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and Community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England.

As part of the NPSP, the Adult Inpatient Survey has been conducted annually since 2002. CQC use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The Adult Inpatient Survey 2025

The survey was administered by the Survey Coordination Centre (SCC) at Picker Institute. A total of 160,829 patients were invited to participate in the survey across 130 acute and specialist NHS trusts. Completed responses were received from 58,139 patients, an adjusted* response rate of 38%.

Patients were eligible to participate in the survey if they were aged 16 years or over, had spent at least one night in hospital, and were not admitted to maternity or psychiatric units. Trusts sampled patients who met the eligibility criteria and were discharged from hospital during November 2025. A full list of eligibility criteria can be found in the survey sampling instructions.

Fieldwork took place between January and April 2026.

Trend data

The Adult Inpatient 2025 survey was conducted using a push-to-web methodology (offering both online and paper completion). There were minor questionnaire changes, including three new questions and changes to question wording. The 2025 results are comparable with data from the Adult Inpatient 2020, 2021, 2022, 2023, and 2024 surveys, unless a question has changed or there are other reasons for lack of comparability such as changes in organisation structure of a trust. Where results are comparable, a section on historical trends has been included.

Further information about the survey

- For published results and for more information on the Adult Inpatient Survey please visit the NHS Survey website.
- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

*The adjusted base is calculated by subtracting the number of questionnaires returned as undeliverable, or if someone had died, from the total number of questionnaires sent out. The adjusted response rate is then calculated by dividing the number of returned useable questionnaires by the adjusted base.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement.

This report also includes site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that the performance ratings presented here may differ from that presented in the trust level benchmarking. More information can be found in the How to interpret benchmarking in this report slides.

Standardisation

Demographic characteristics, such as age and gender, can influence patients’ experience of care and the way they report it. Results from previous years show that men tend to report more positive experiences than women, and older people more so than younger people. Since trusts have differing profiles of patients, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual patient responses to account for differences in demographic profile between trusts.

For each trust, results have been standardised by the age, sex and route of admission (emergency or elective) of respondents to reflect the ‘national’ age, sex, and route of admission distribution (based on all respondents to the survey).This helps ensure that no trust will appear better or worse than another because of its patient profile and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results. Site level results are standardised in the same way.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example Q1) and others are ‘routing questions’, which are designed to filter out respondents to whom the following questions do not apply (for example Q5). These questions are not scored. Please refer to the scored questionnaire for further details. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied. More information can be found in the ‘How questions are scored’ slide.

National average

The ‘national average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document. which is on the 'Analysis and Reporting' section of the 2025 Adult Inpatient Survey webpage on the NHS Surveys website.

Using the survey results

Navigating this report

This report is split into six sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the patients who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Scoring and benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part, using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Section score slides also include a comparison with other trusts in your region. It may be helpful to compare yourself with regional trusts, so you can learn from and share learnings with trusts in your area who care for similar populations.
- **Trust and site results** – includes the score for your trust and breakdown of scores across sites within your trust. Internal benchmarking may be helpful so you can compare sites within your organisation, sharing best practice within the trust and identifying any sites that may need attention.
- **Change over time** – includes your trust's mean score for each evaluative question across survey years, 2020, 2021, 2022, 2023 and 2024. Significance test tables, below the chart, allows you to see if your trust has made statistically significant improvements between survey years.
- **Comparison to other trusts** – includes where your trust has performed better or worse in comparison to other trusts.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'Scoring and Benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the How to interpret benchmarking in this report slides.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results: technical document
- National and trust-level data for all trusts who took part in the 2025 Adult Inpatient Survey.
- Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys
- Information about how CQC monitors hospitals

Headline results

This section includes:

- information about your trust population and sample
- an overview of benchmarking for your trust
- the best and worst scores for your trust presented in charts (slide 10) and poster format (slide 11)

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of patients who took part in the survey.

1250 invited to take part

499 completed

31% urgent/emergency admission

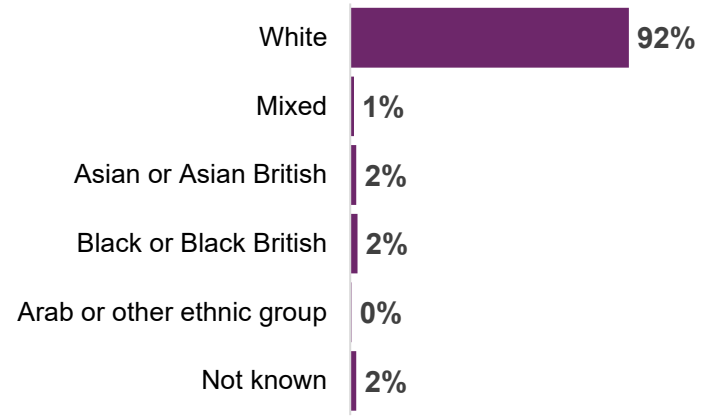
69% planned admission

41% response rate

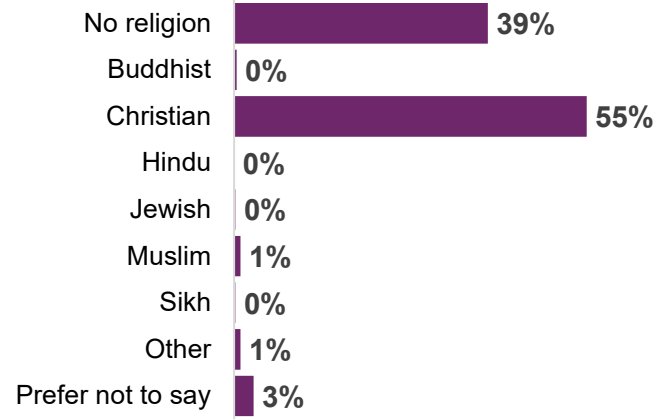
38% average response rate for all trusts

46% response rate for your trust last year

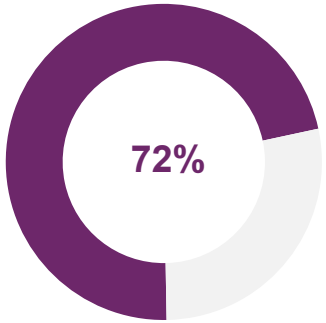
Ethnicity



Religion



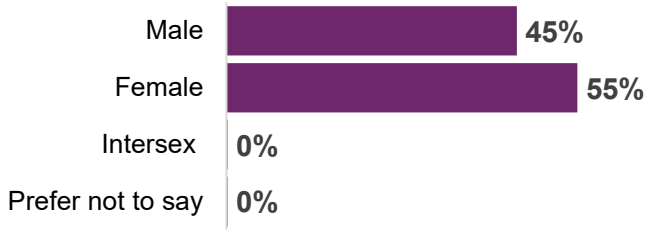
Long-term conditions



of participants said they have **physical or mental health conditions, disabilities or illnesses** that have lasted or are expected to last 12 months or more (excluding those who selected "I would prefer not to say").

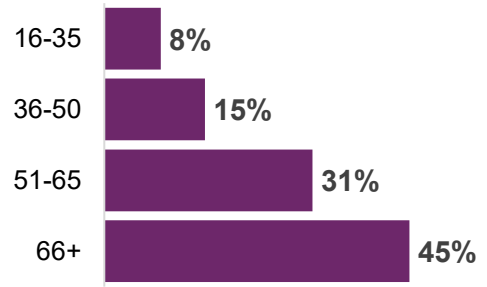
Sex

At birth were you assigned as…



0% of patients said their **gender is different from the sex they were assigned with at birth**.

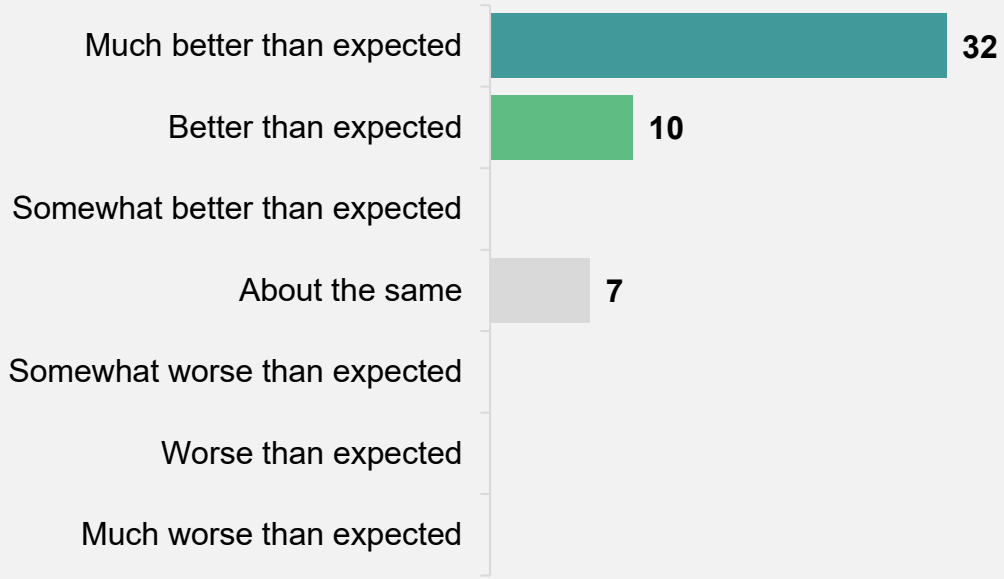
Age



Summary of findings for your trust

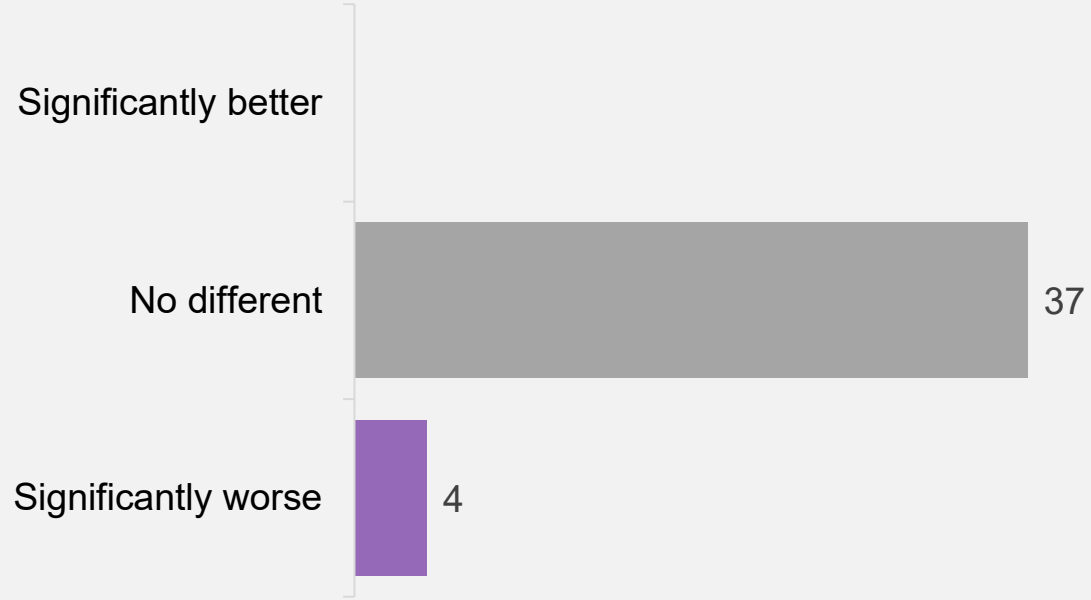
Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2025 vs 2024.



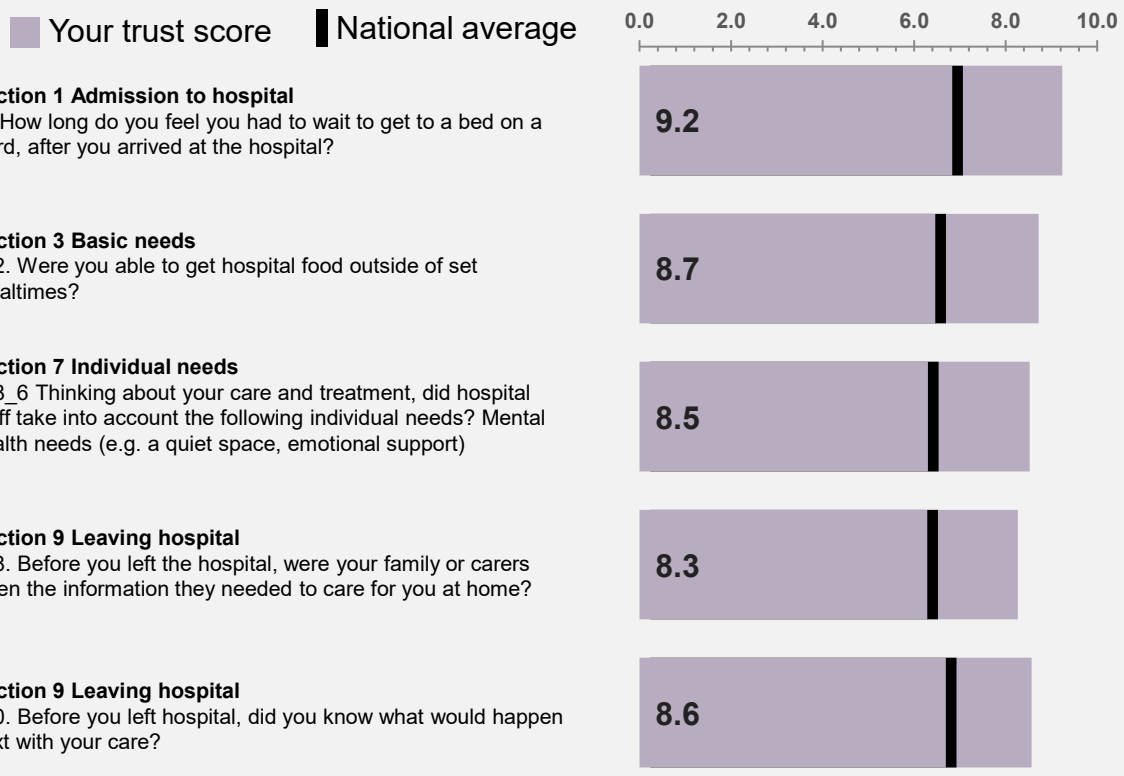
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the section "Comparison to other trusts".

Best and worst performance relative to the national average

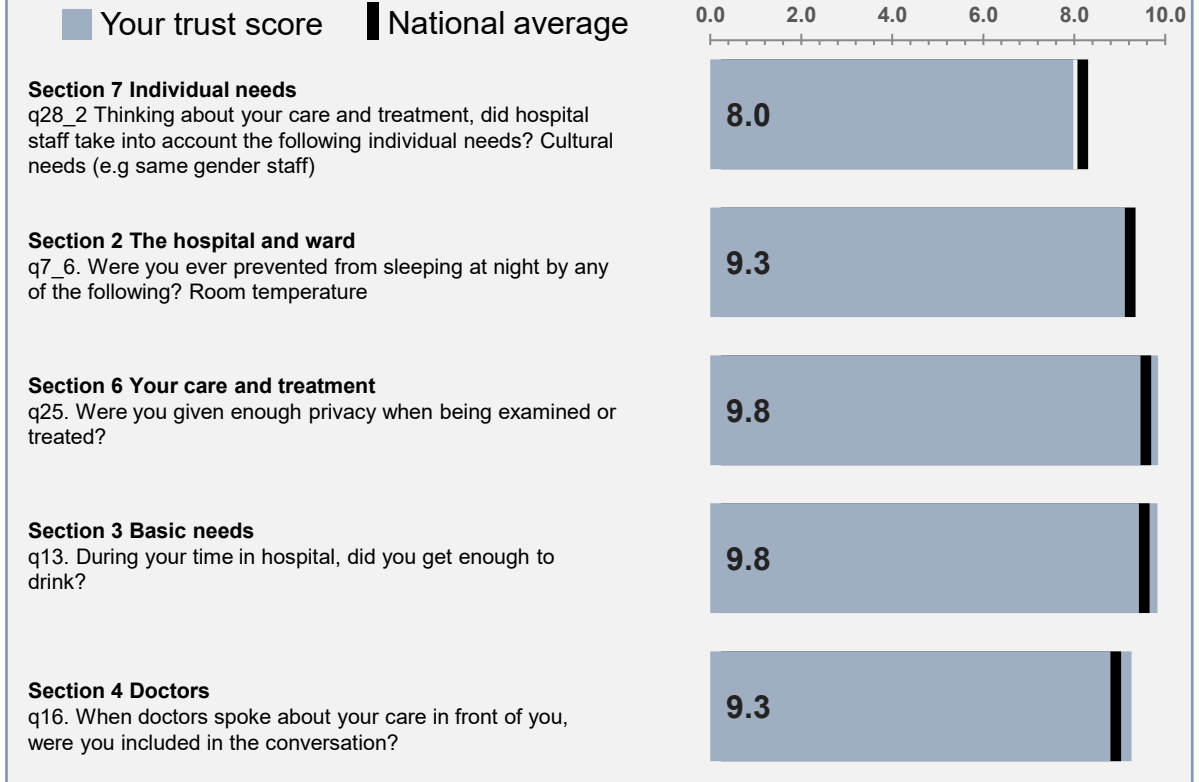
These five questions are calculated by comparing your trust's results to the national average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.

Top five scores (compared with national average)



Bottom five scores (compared with national average)



NHS Adult Inpatient Survey 2025

Results for Queen Victoria Hospital NHS Foundation Trust

Where patient experience is best

- ✓ **Wait to get a bed:** The wait to get a bed on a ward after arrival
- ✓ **Food:** Patients being able to get hospital food outside of set mealtimes
- ✓ **Individual needs:** Staff taking into account patients' individual needs: Mental health needs
- ✓ **Leaving hospital:** Family / carers given information to care for patient at home
- ✓ **Next steps:** Patients knowing what would happen next with their care before they left hospital

Where patient experience could improve

- ○ **Individual needs:** Staff taking into account patients' individual needs: Cultural needs
- ○ **Sleeping:** Patients being prevented from sleeping at night due to room temperature
- ○ **Privacy:** Patients being given enough privacy when being examined or treated
- ○ **Drink:** Patients getting enough to drink
- ○ **Inclusion in conversation:** Patients being included in conversation when doctors are speaking about their care

These questions are calculated by comparing your trust's results to the average of all trusts. "Where patient experience is best": These are the five results for your trust that are highest compared with the national average. "Where patient experience could improve": These are the five results for your trust that are lowest compared with the national average.



This survey looked at the experiences of people who were discharged from an NHS acute hospital in November 2025. Between January 2026 and April 2026, a questionnaire was sent to 1250 inpatients at Queen Victoria Hospital NHS Foundation Trust who had attended in late 2025. Responses were received from 499 patients at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

Scoring and benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better, or worse compared with most other trusts
- a comparison of section scores with other trusts in your region

Please note: If data is missing, this is due to a low number of responses.

How questions are scored

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the patient's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive patient experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of patient experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Example of how questions are scored

The following provides an example for the scoring system applied for each respondent. For question 14 "When you asked doctors questions, did you get answers you could understand":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No, never" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer codes "I did not have any questions" and "I did not feel able to ask questions" would not be scored, as they do not have a clear bearing on the trust's performance in terms of patient experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

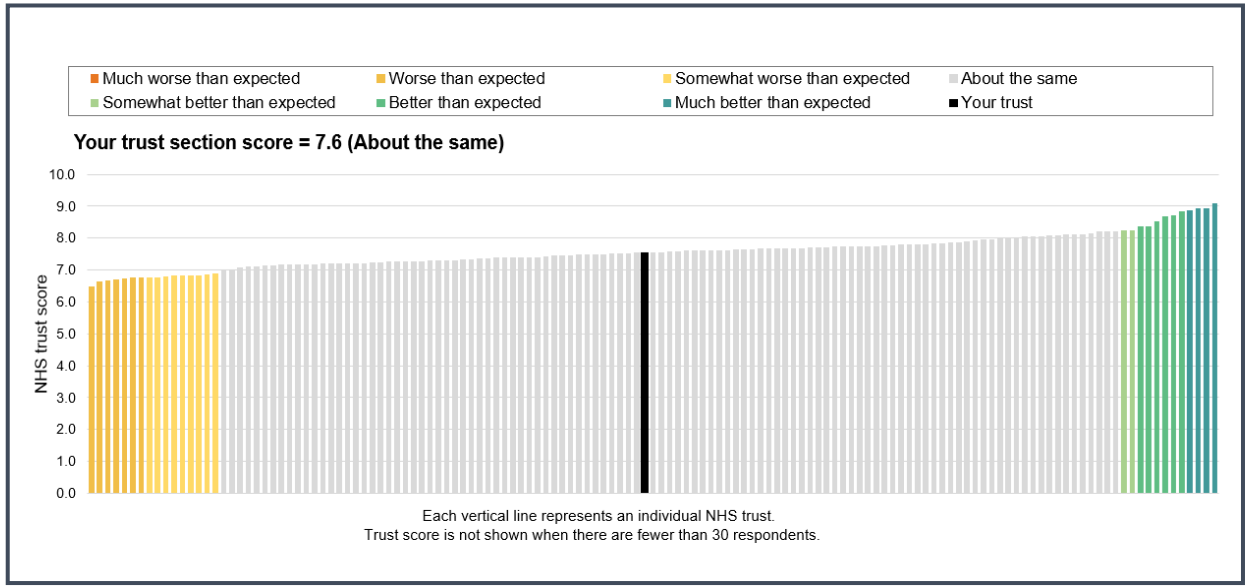
How to interpret benchmarking in this report

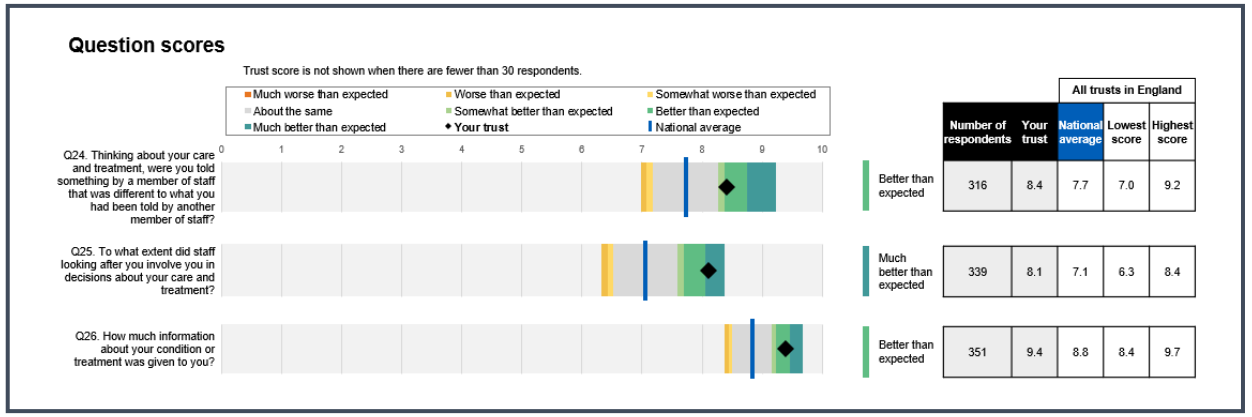
Trust level benchmarking

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven possible sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange section** of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange section** of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

Trust level benchmarking

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Site level benchmarking

The charts in the ‘trust and site results’ section present site level benchmarking. This allows you to compare the results for sites within your trust with all other sites across trusts. It is important to note that there may be differences between the average score of the sites provided and the overall score for the trust. This may be related to the size of the sites, results for suppressed sites or weighting, as sites and trusts are weighted separately. In addition, if a single site result is presented for a trust, the ‘expected range’ category may differ: although the score achieved will be the same for both the site and for the trust, the upper and lower boundary levels will differ between the two due to them being calculated differently in each case.

If fewer than 30 responses were received from patients discharged from a site, no scores will be displayed for that site.

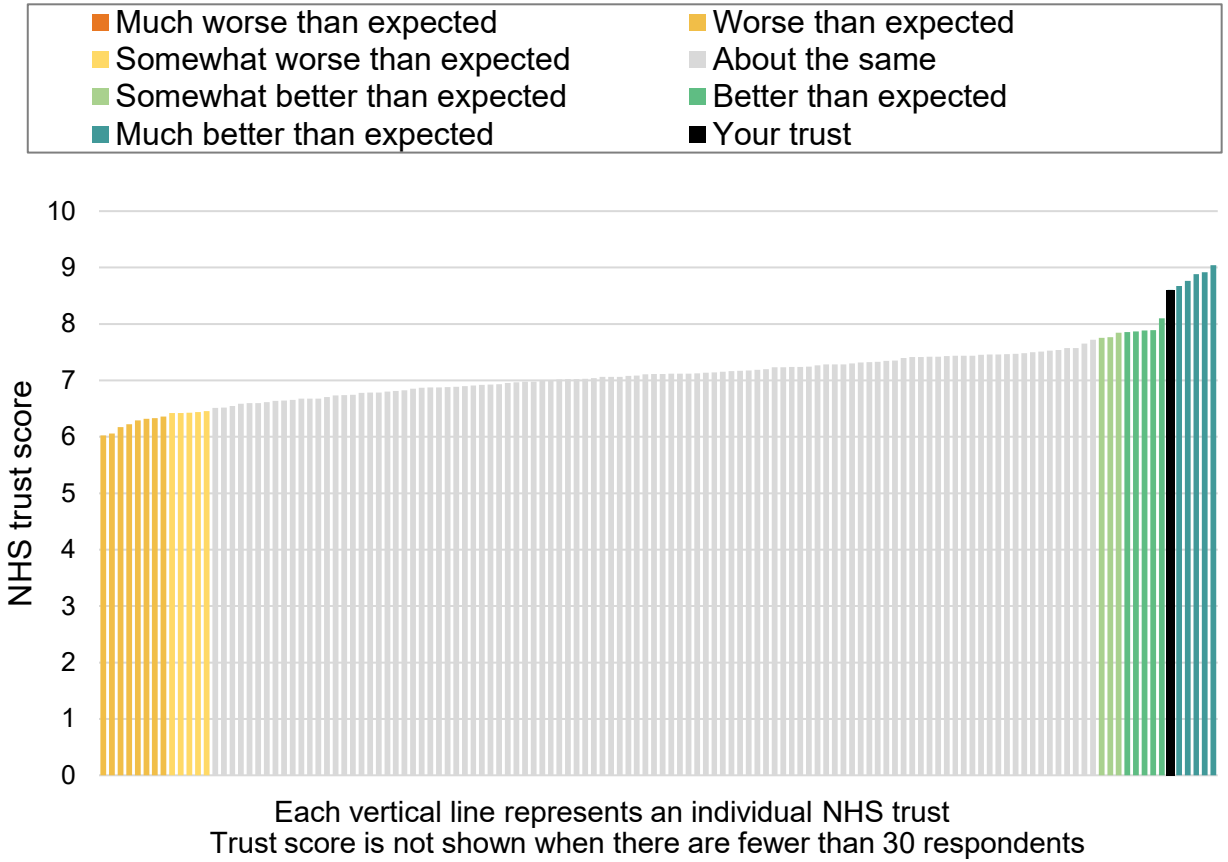
Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

Section 1. Admission to hospital

Section score

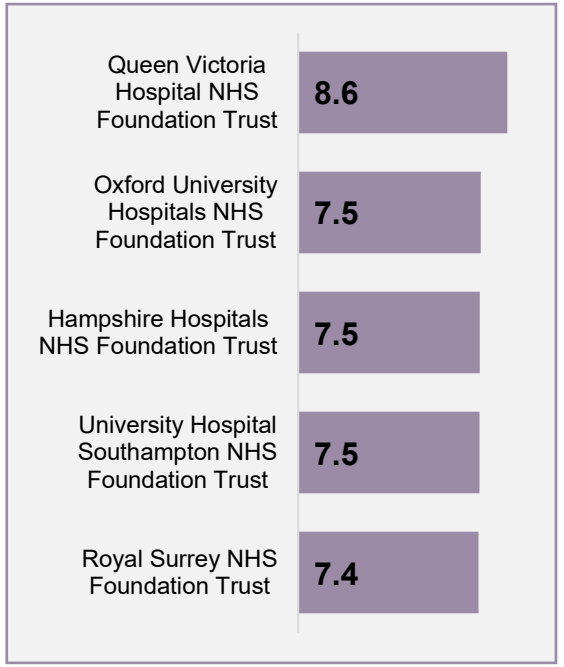
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.6 Much better than expected

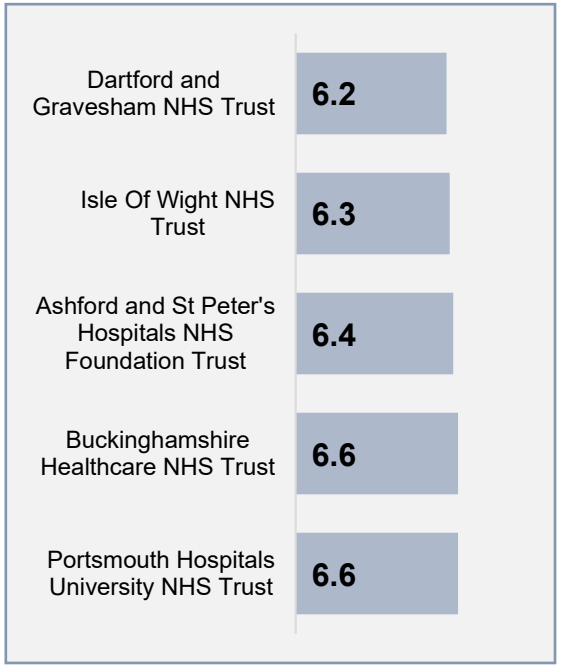


Comparison with other trusts within your region

Trusts with the highest scores

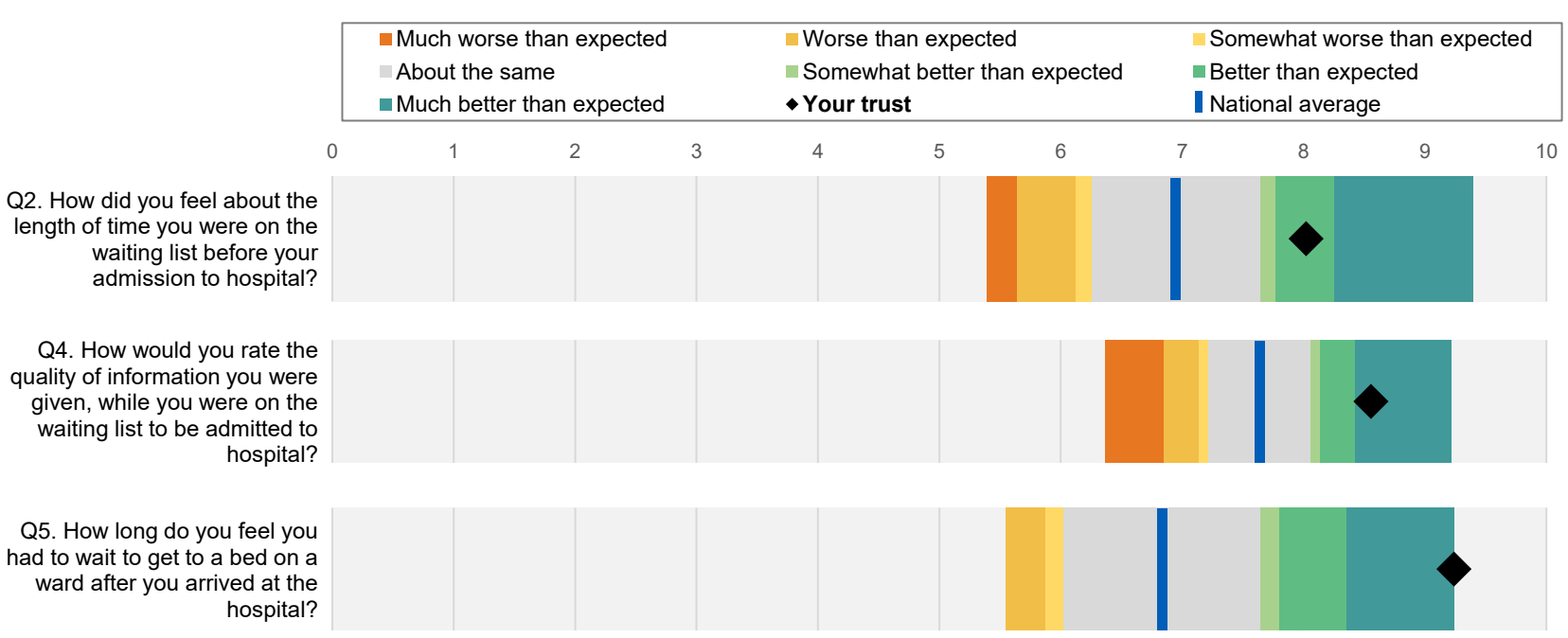


Trusts with the lowest scores



Section 1. Admission to hospital (continued)

Question scores



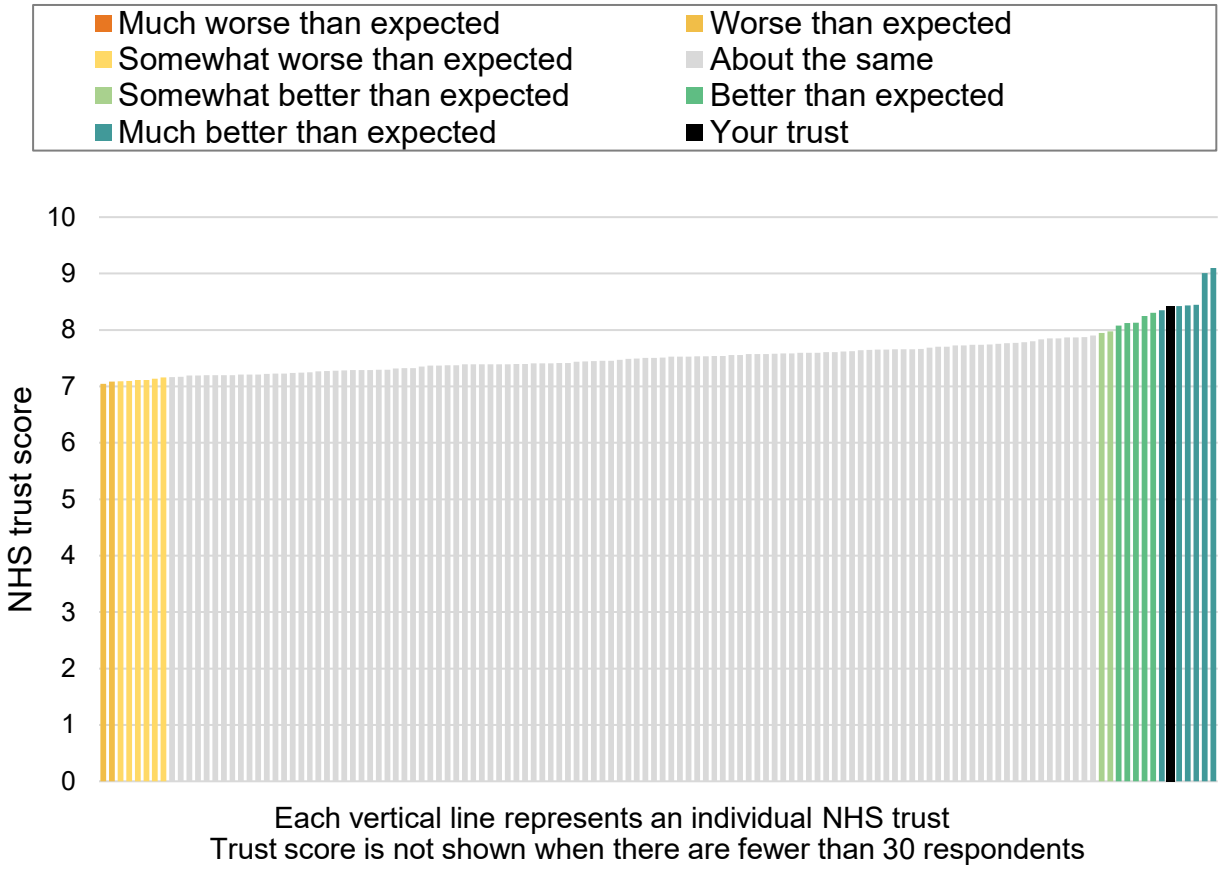
		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Better than expected				
322	8.0	6.9	5.4	9.4
Much better than expected				
326	8.6	7.6	6.4	9.2
Much better than expected				
486	9.2	6.8	5.5	9.2

Section 2. The hospital and ward

Section score

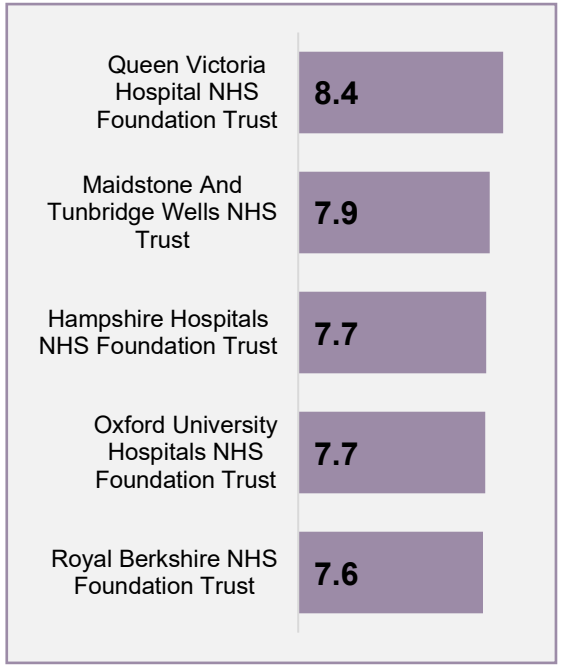
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.4 Much better than expected

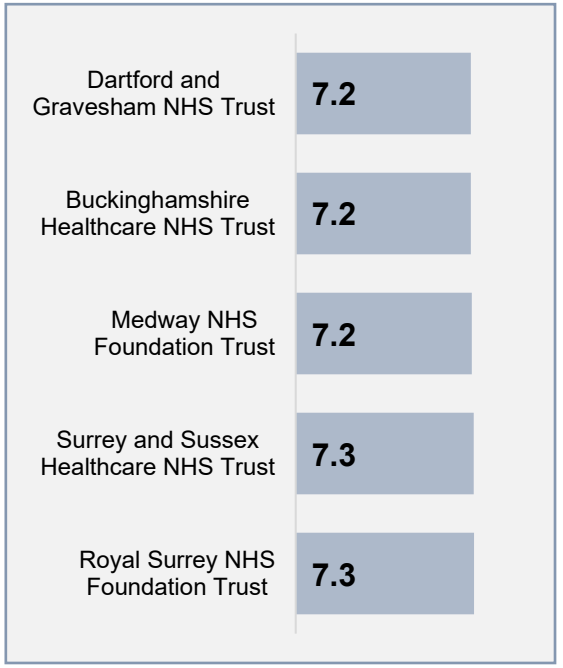


Comparison with other trusts within your region

Trusts with the highest scores

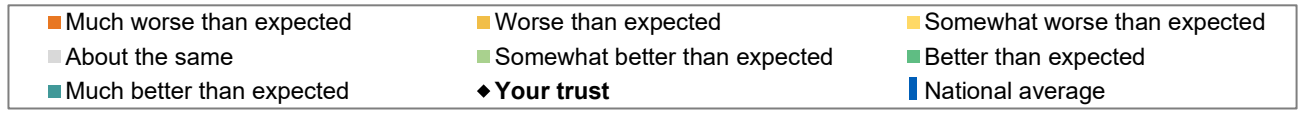


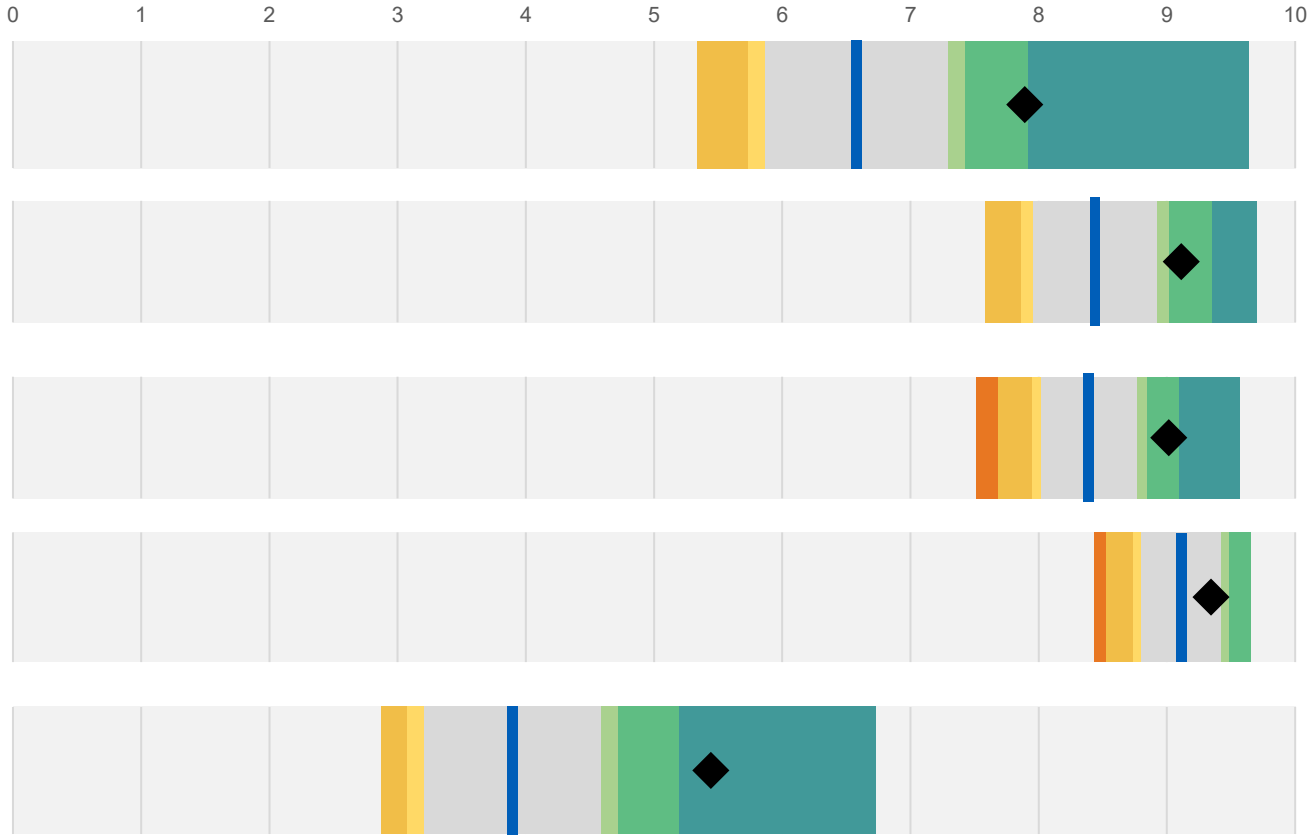
Trusts with the lowest scores



Section 2. The hospital and ward (continued)

Question scores

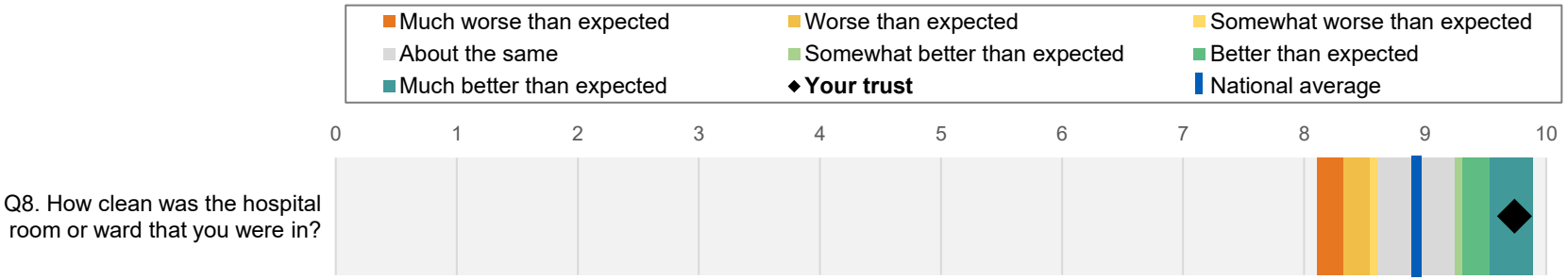




		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Q7_1. Were you ever prevented from sleeping at night by any of the following? Noise from other patients — Better than expected	490	7.9	6.6	5.3	9.6
Q7_2. Were you ever prevented from sleeping at night by any of the following? Noise from staff — Better than expected	490	9.1	8.4	7.6	9.7
Q7_4. Were you ever prevented from sleeping at night by any of the following? Hospital lighting — Better than expected	490	9.0	8.4	7.5	9.6
Q7_6. Were you ever prevented from sleeping at night by any of the following? Room temperature — About the same	490	9.3	9.1	8.4	9.7
Q7_8. Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping — Much better than expected	490	5.4	3.9	2.9	6.7

Section 2. The hospital and ward (continued)

Question score



Much better than expected

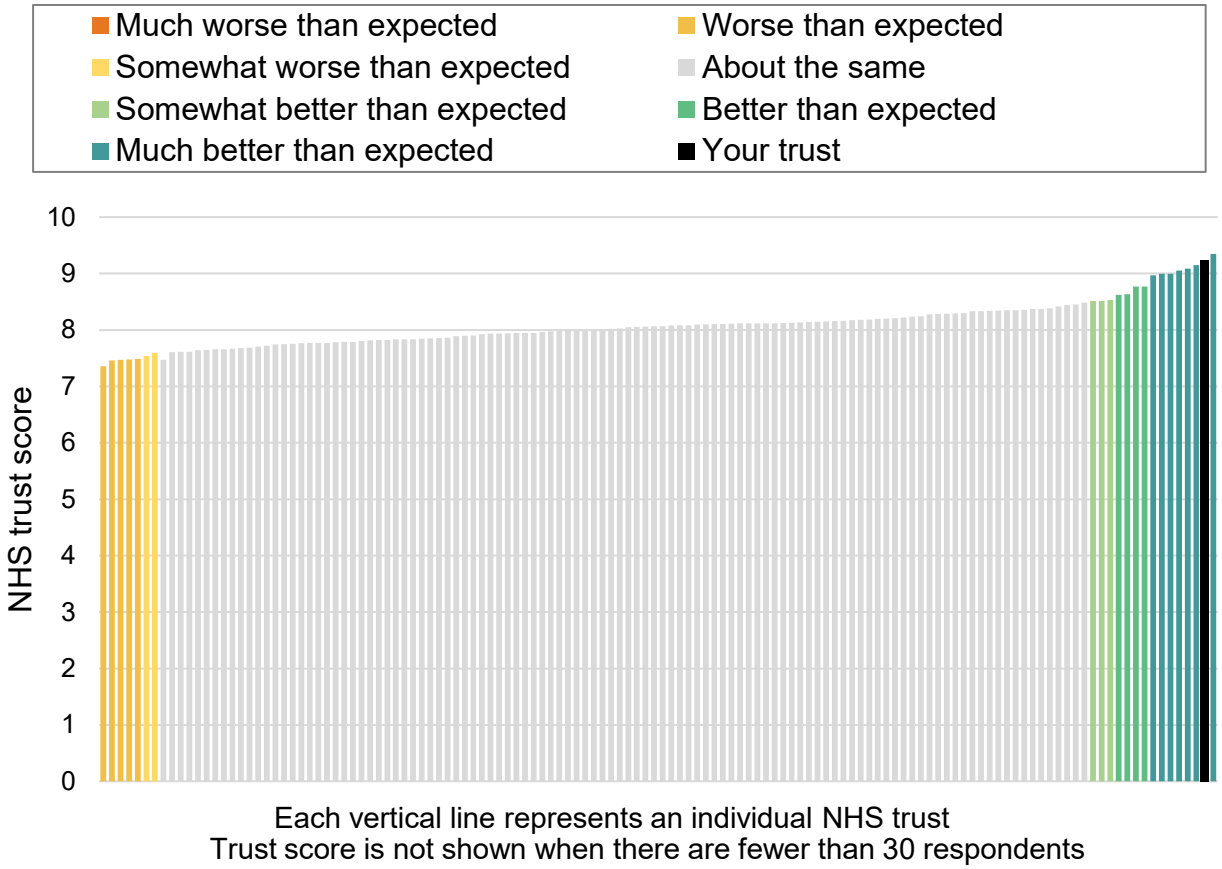
		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
493	9.7	8.9	8.1	9.9

Section 3. Basic needs

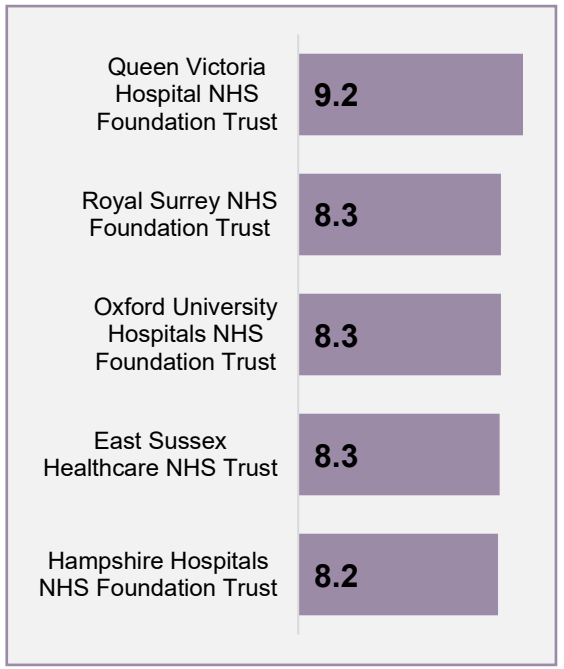
Section score

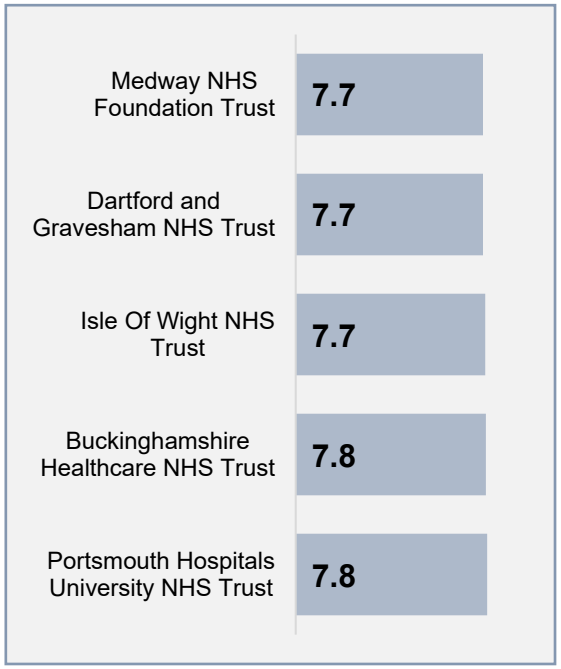
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.2 Much better than expected



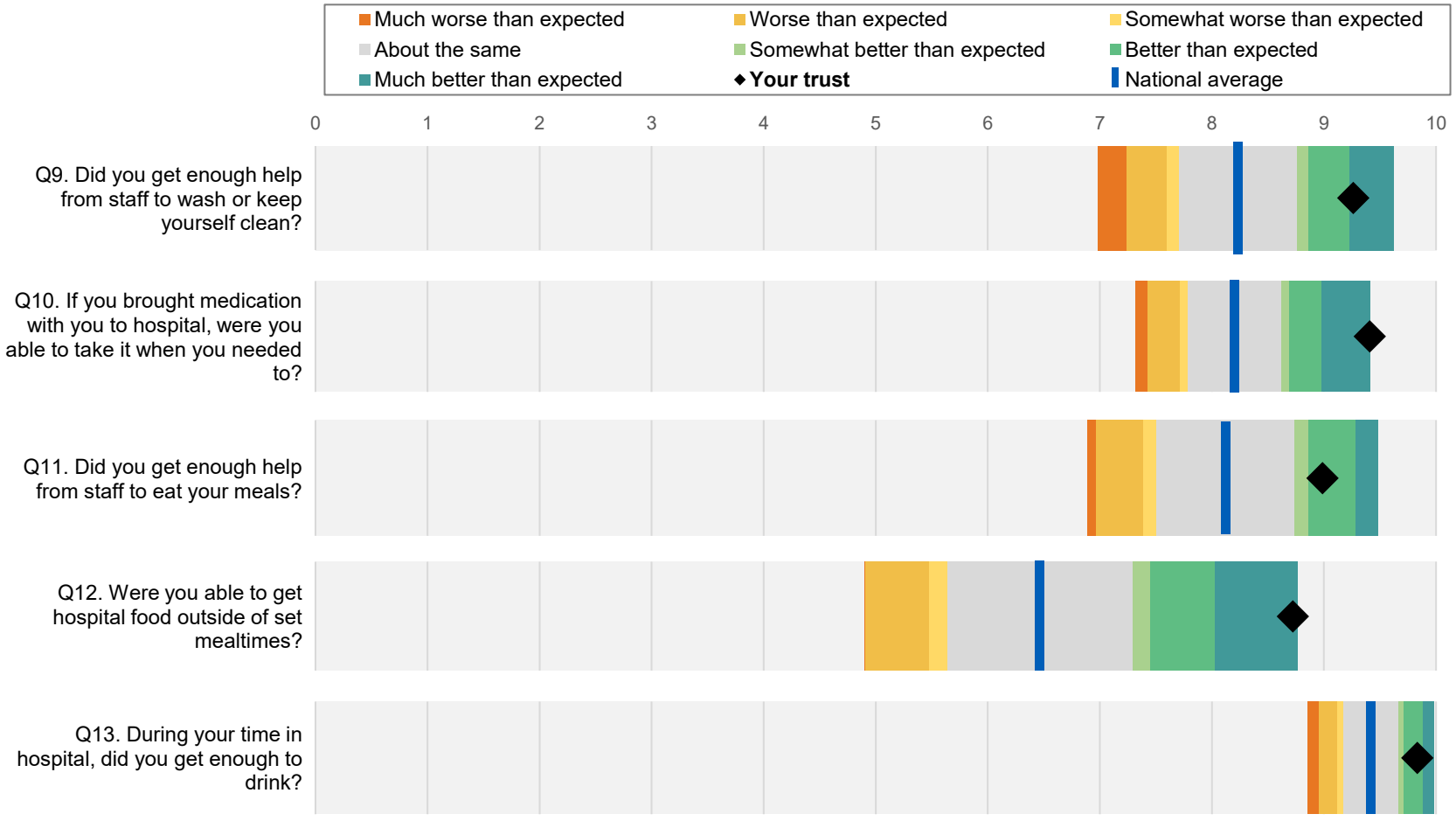
Comparison with other trusts within your region





Section 3. Basic needs (continued)

Question scores



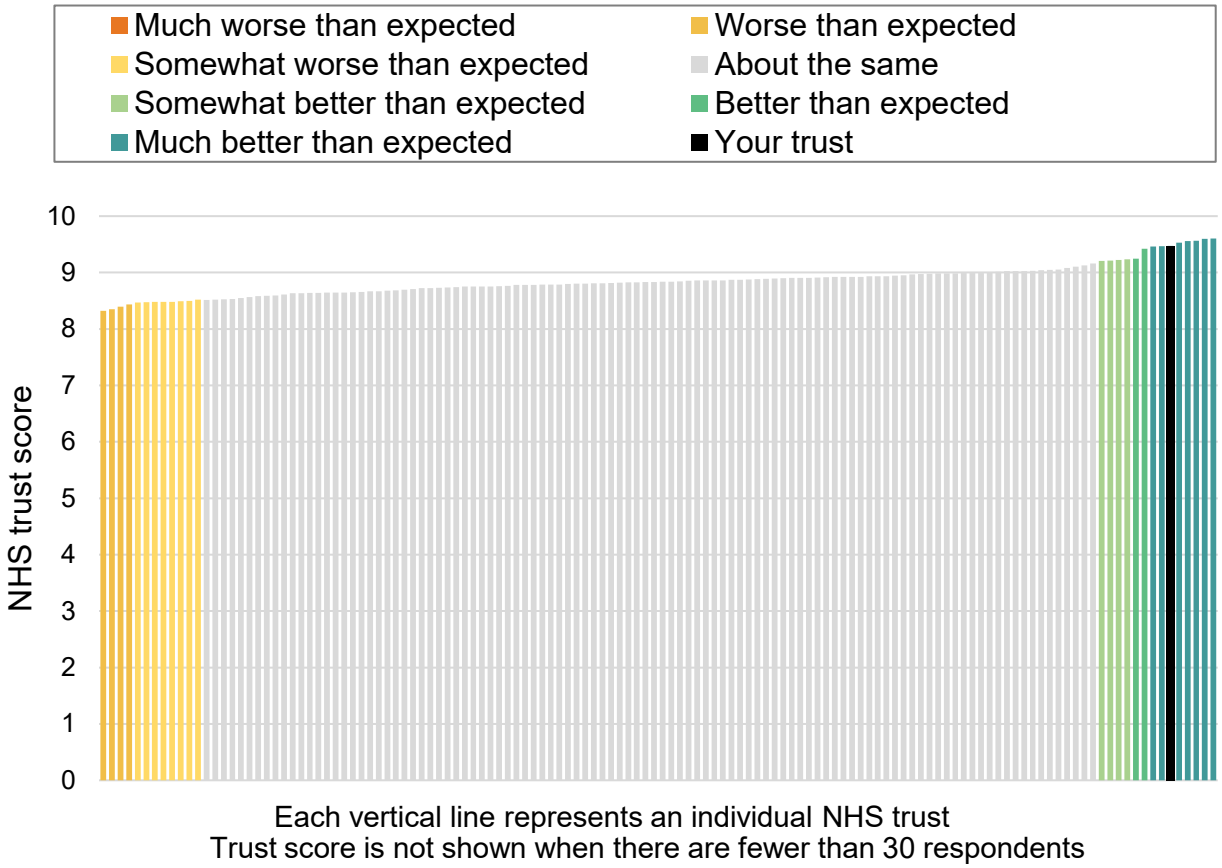
		All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
Much better than expected	304	9.3	8.2	7.0	9.6
Much better than expected	297	9.4	8.2	7.3	9.4
Better than expected	161	9.0	8.1	6.9	9.5
Much better than expected	169	8.7	6.5	4.9	8.8
Better than expected	470	9.8	9.4	8.9	10.0

Section 4. Doctors

Section score

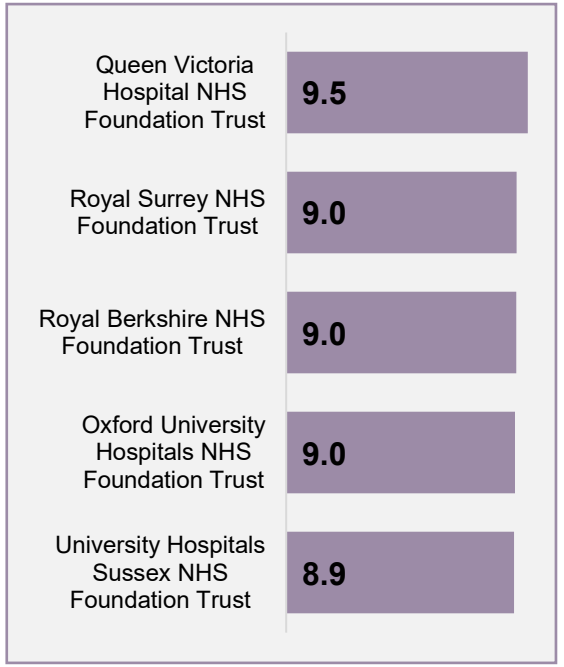
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.5 Much better than expected

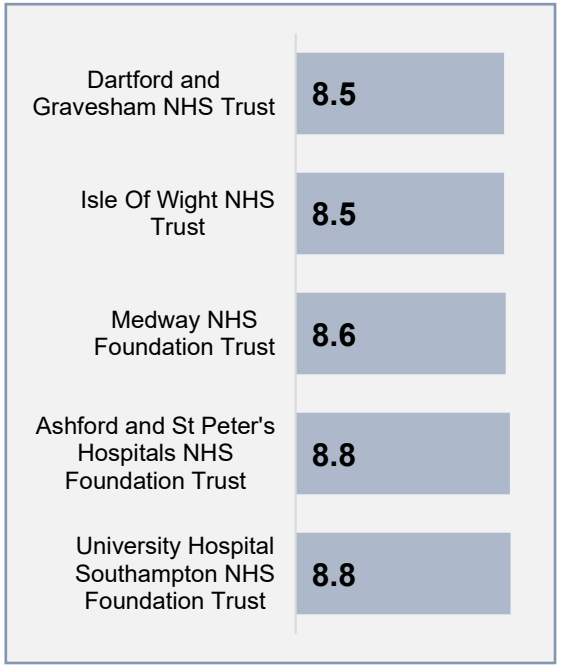


Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



Section 4. Doctors (continued)

Question scores



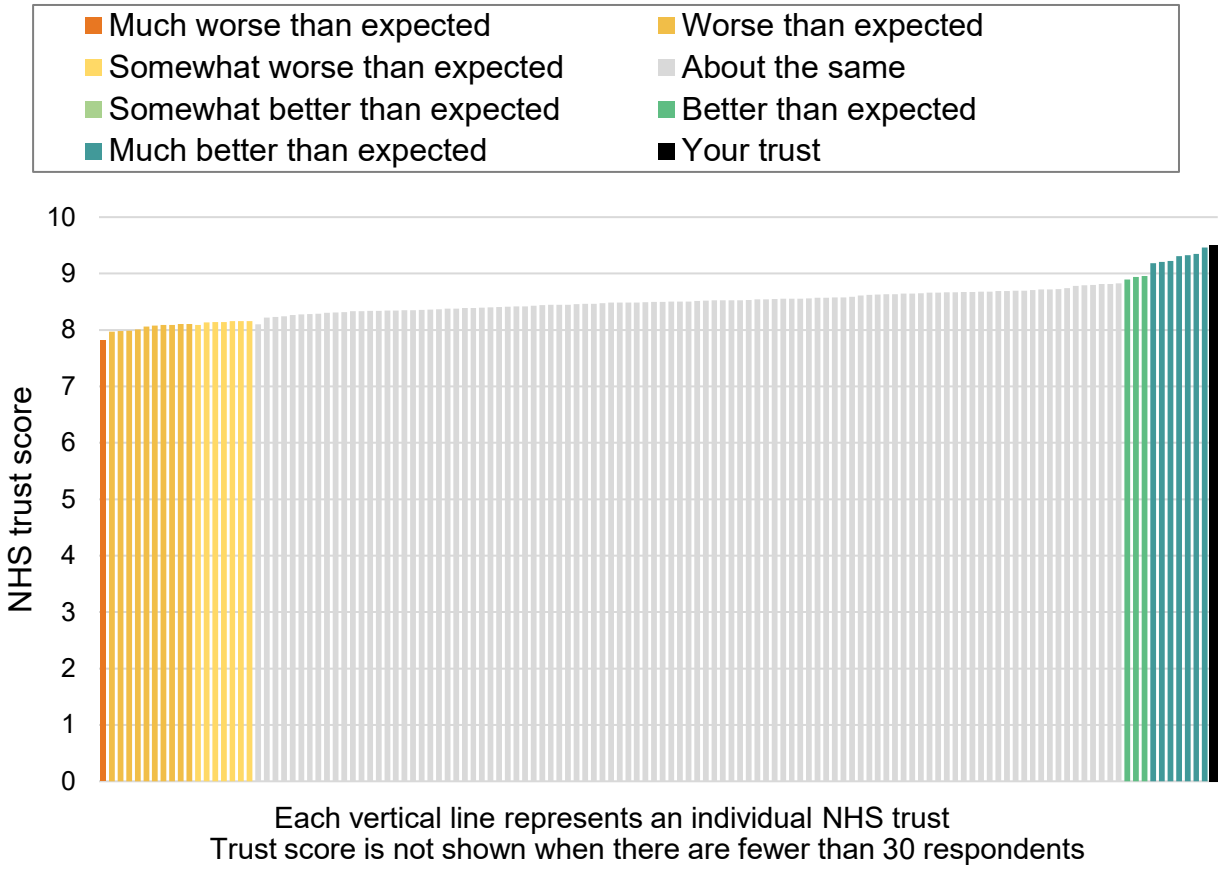
		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Much better than expected: 447	9.5	8.7	8.0	9.5
Much better than expected: 491	9.7	9.1	8.6	9.8
Better than expected: 474	9.3	8.8	8.1	9.7

Section 5. Nurses

Section score

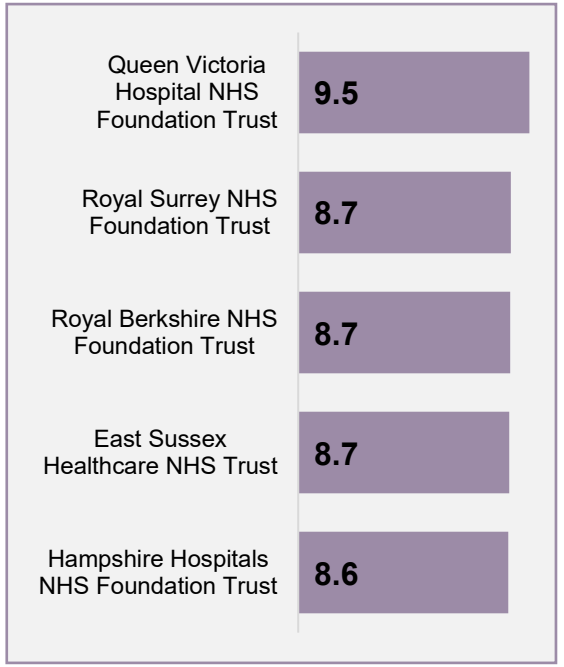
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.5 Much better than expected

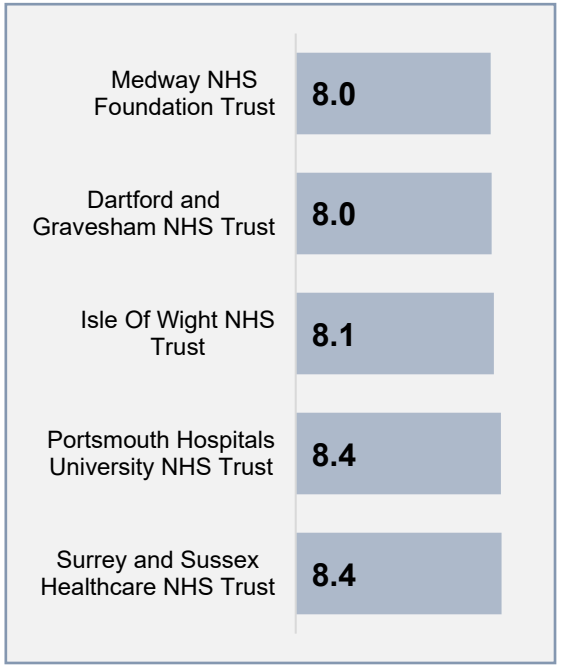


Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



Section 5. Nurses (continued)

Question scores



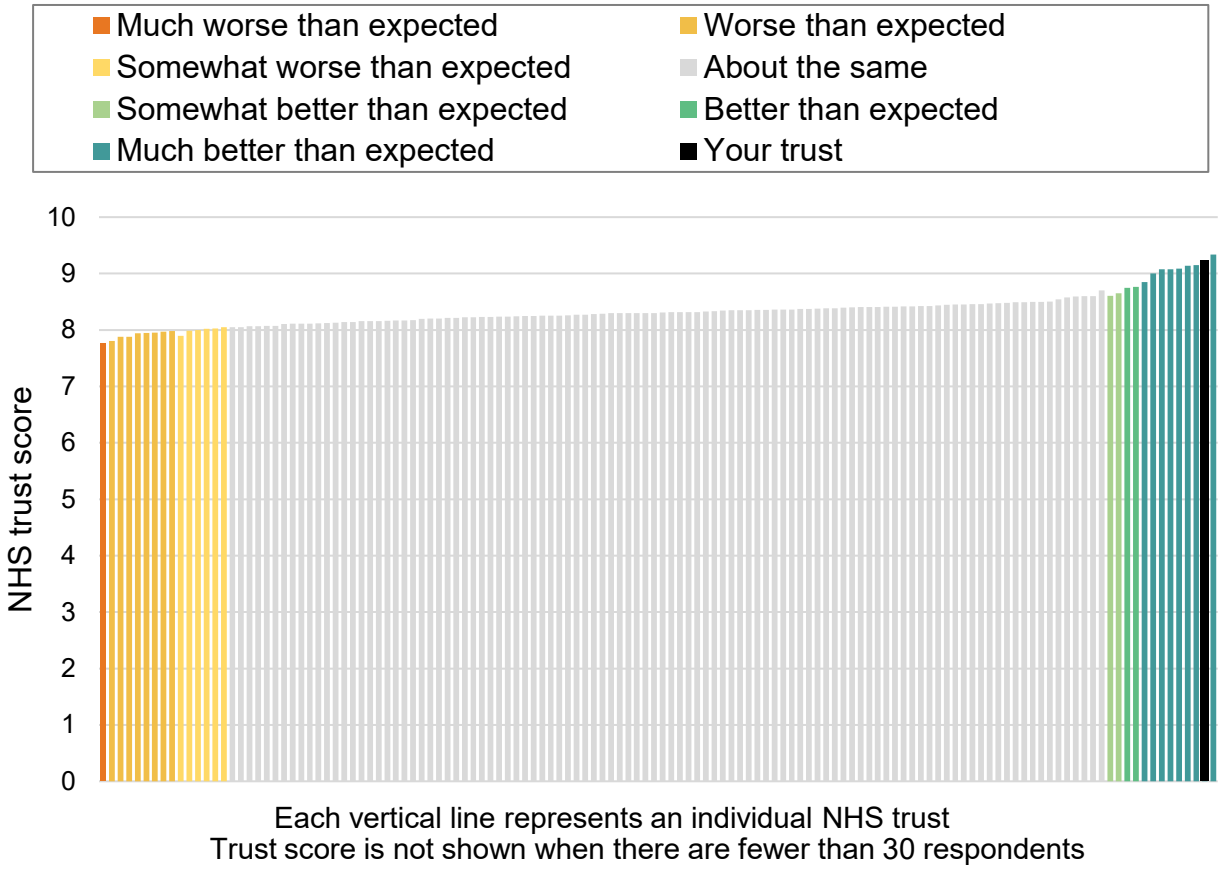
		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Much better than expected				
463	9.5	8.7	8.0	9.6
Much better than expected				
494	9.7	9.0	8.3	9.7
Much better than expected				
487	9.5	8.8	7.9	9.7
Much better than expected				
491	9.3	7.6	6.7	9.3

Section 6. Your care and treatment

Section score

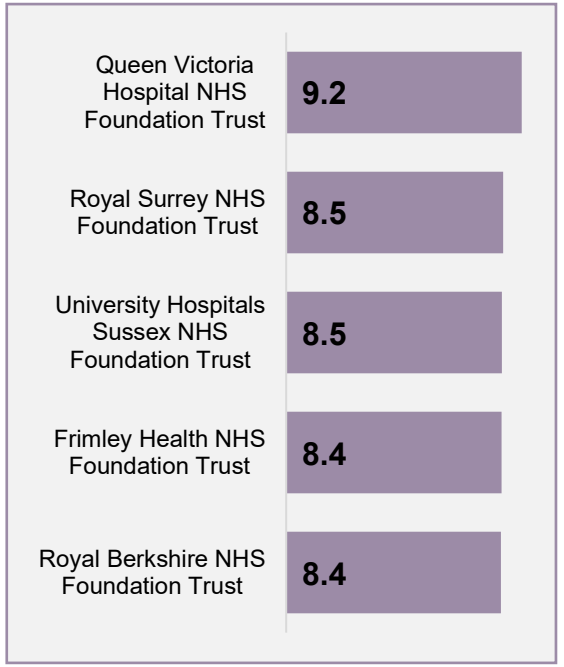
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.2 Much better than expected

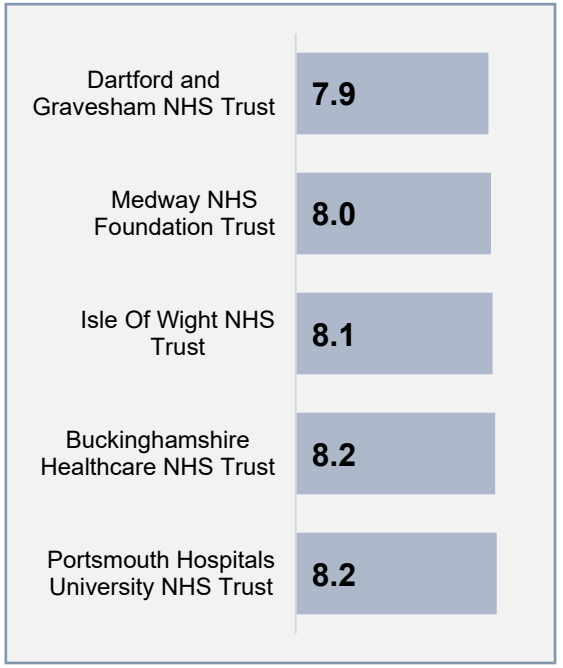


Comparison with other trusts within your region

Trusts with the highest scores

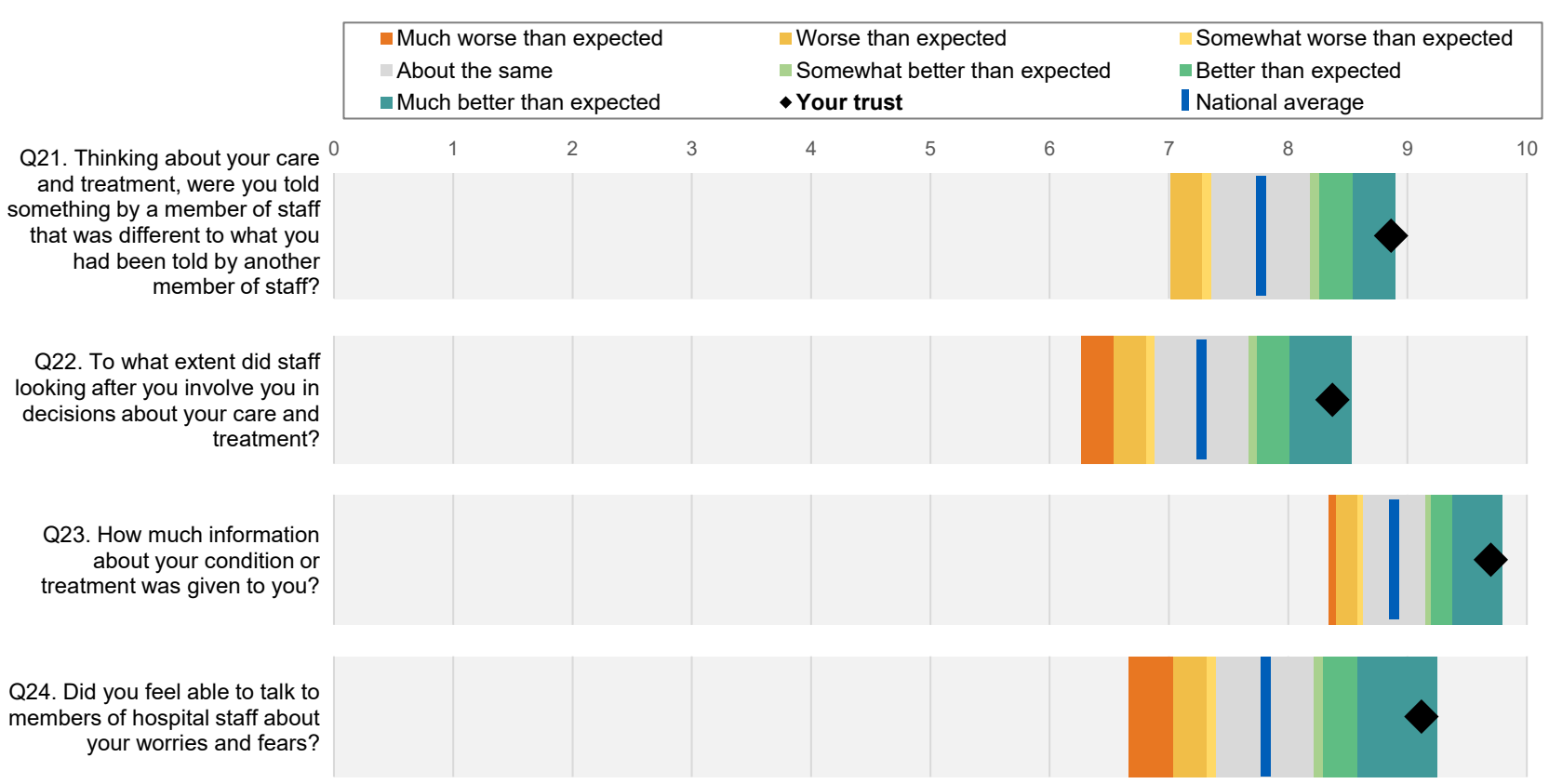


Trusts with the lowest scores



Section 6. Your care and treatment (continued)

Question scores

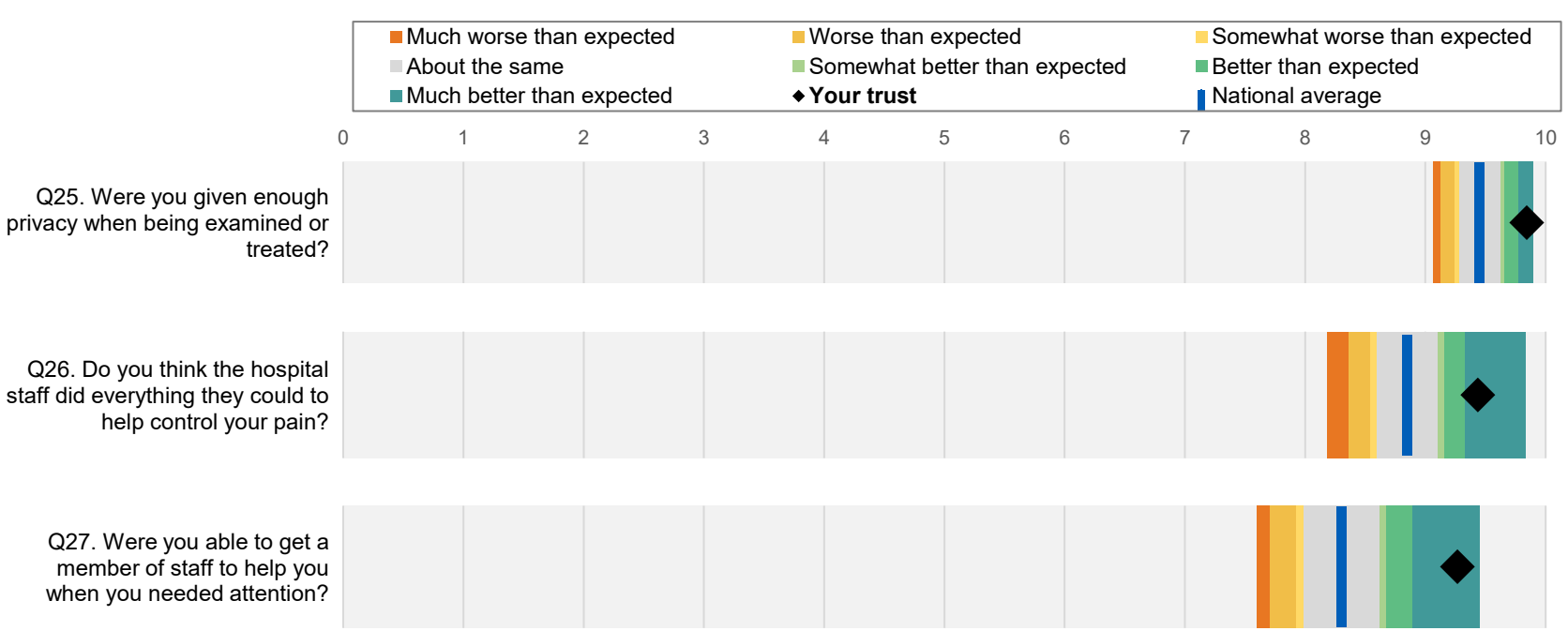


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
458	8.9	7.8	7.0	8.9
465	8.4	7.3	6.3	8.5
485	9.7	8.9	8.3	9.8
390	9.1	7.8	6.7	9.2

Much better than expected

Section 6. Your care and treatment (continued)

Question scores



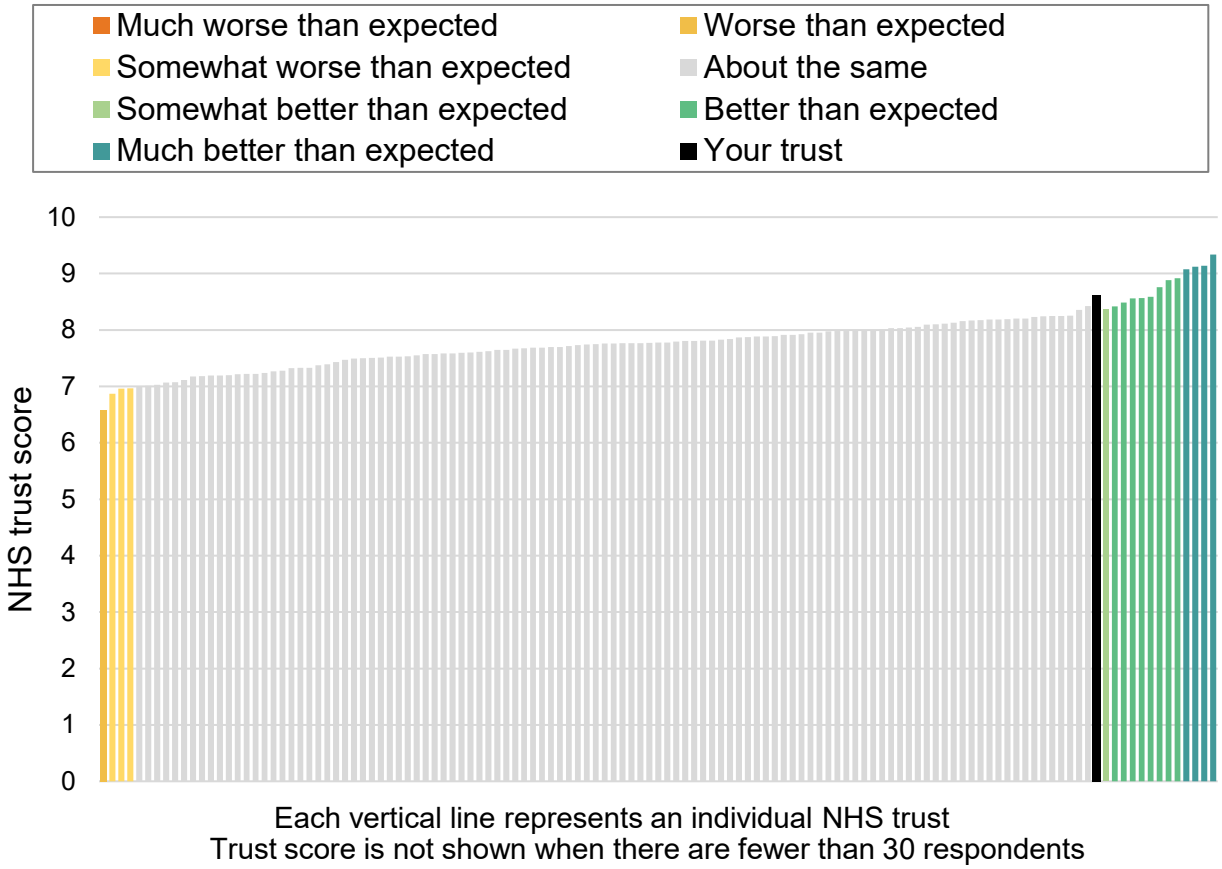
		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Much better than expected: 482	9.8	9.5	9.1	9.9
Much better than expected: 380	9.4	8.8	8.2	9.8
Much better than expected: 410	9.3	8.3	7.6	9.4

Section 7. Individual needs

Section score

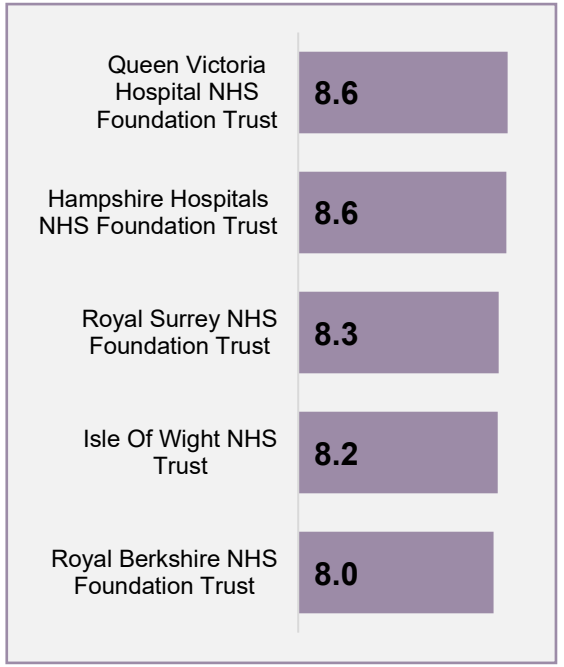
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.6 About the same

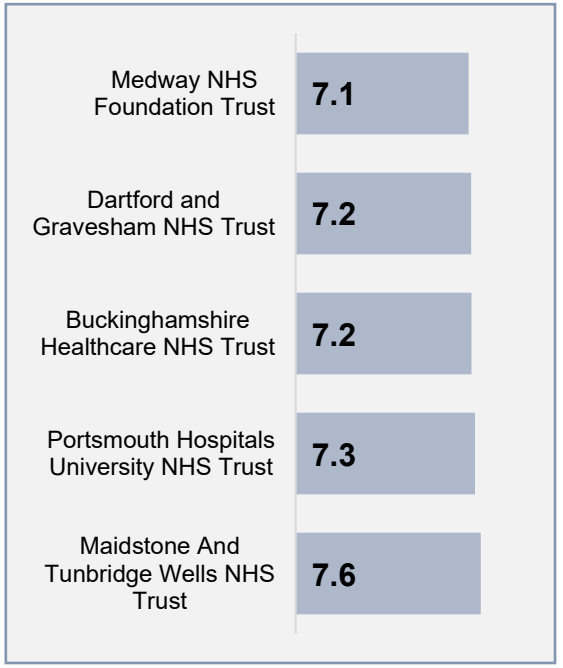


Comparison with other trusts within your region

Trusts with the highest scores

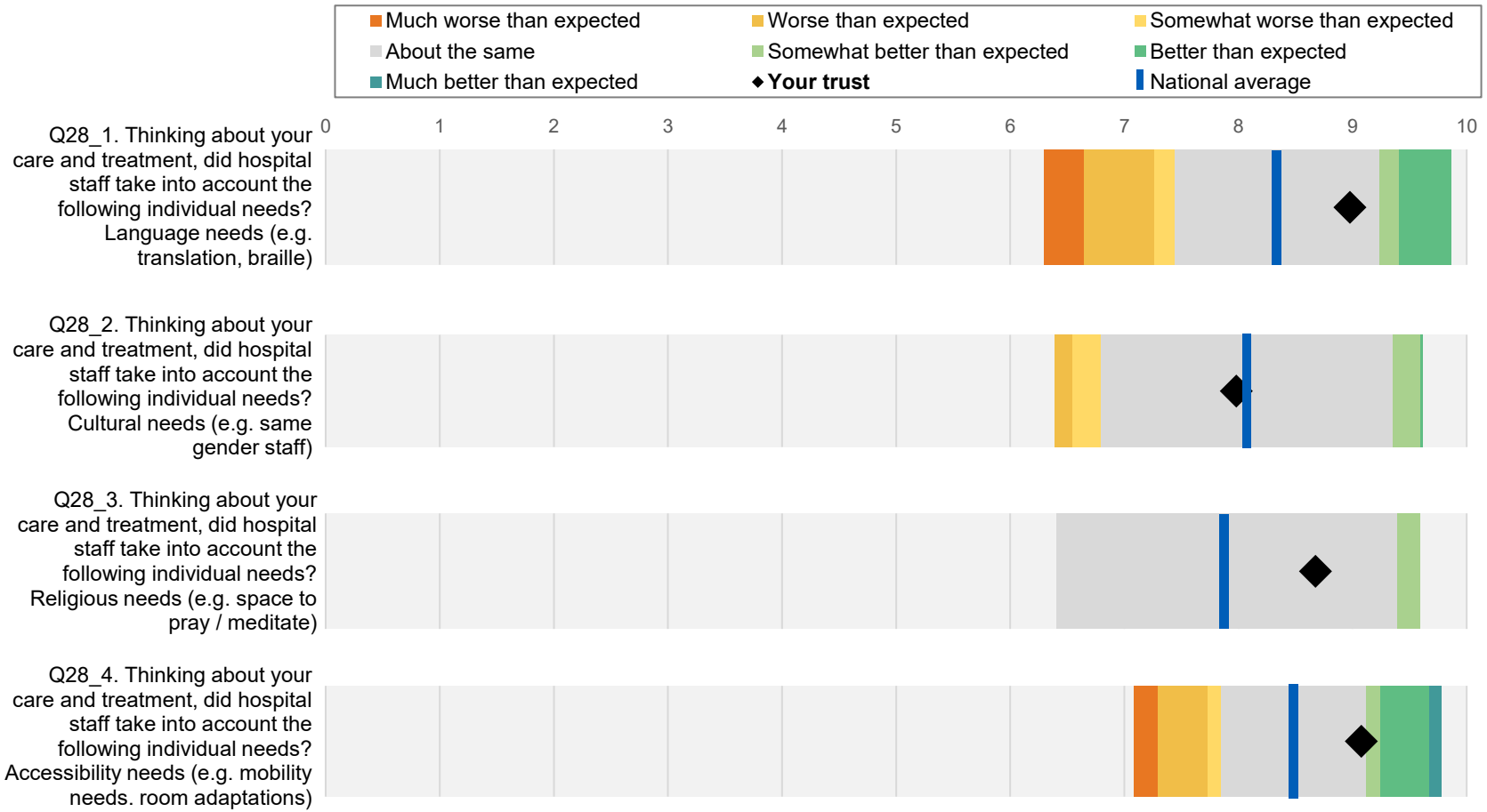


Trusts with the lowest scores



Section 7. Individual needs (continued)

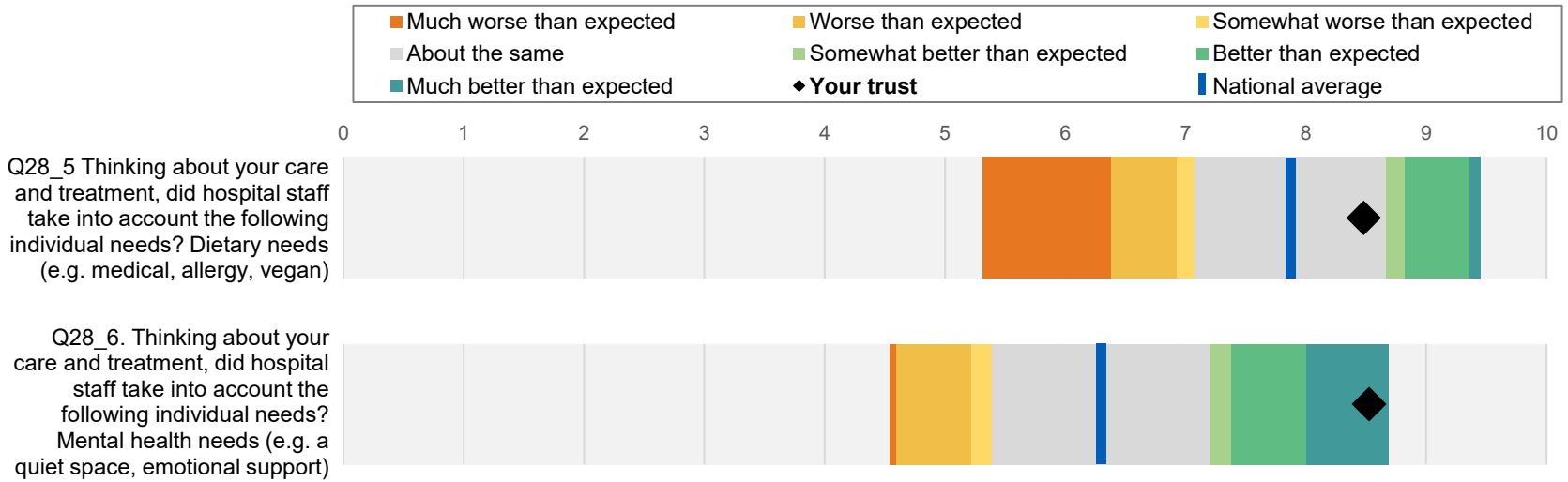
Question scores



		All trusts in England			
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	54	9.0	8.3	6.3	9.9
About the same	57	8.0	8.1	6.4	9.6
About the same	32	8.7	7.9	6.4	9.6
About the same	93	9.1	8.5	7.1	9.8

Section 7. Individual needs (continued)

Question scores



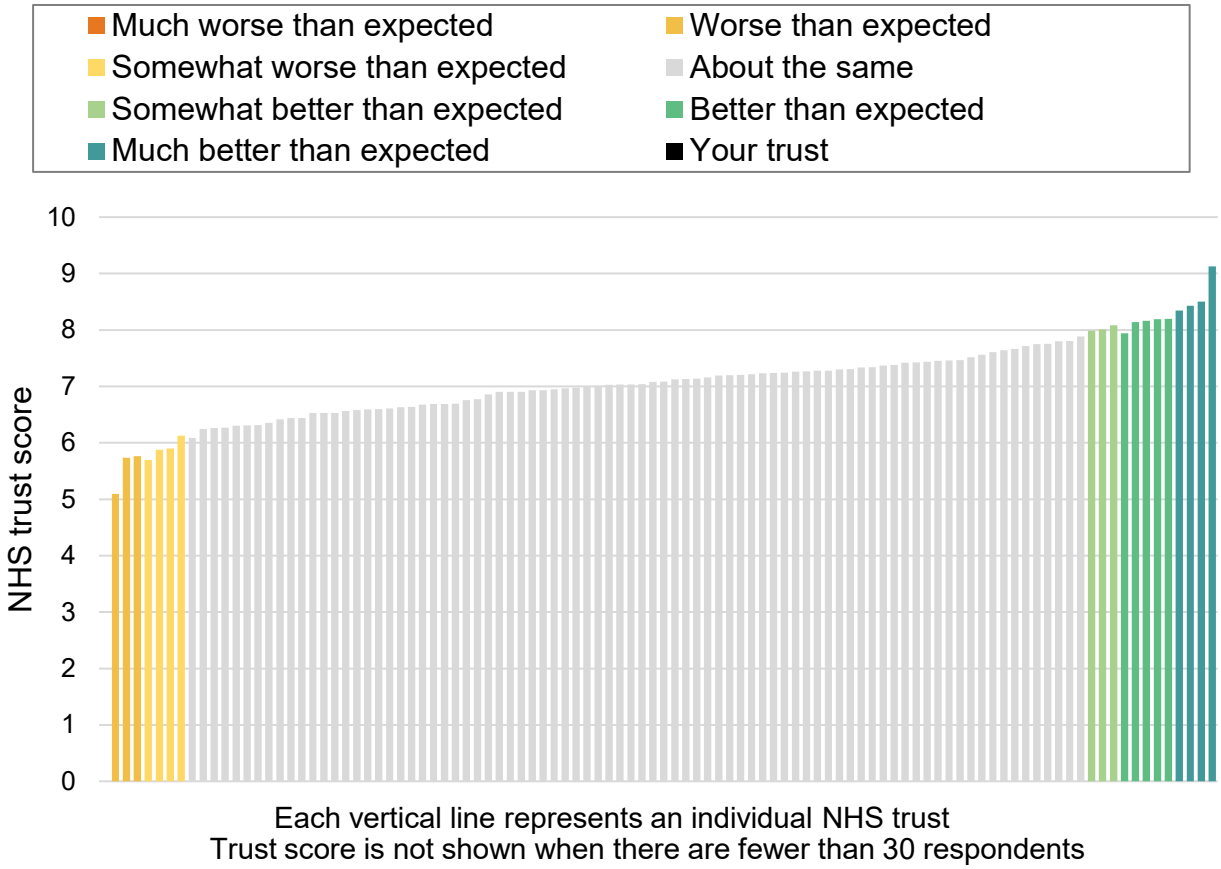
	All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	96	8.5	7.9	5.3	9.5
Much better than expected	80	8.5	6.3	4.5	8.7

Section 8. Virtual wards

Section score

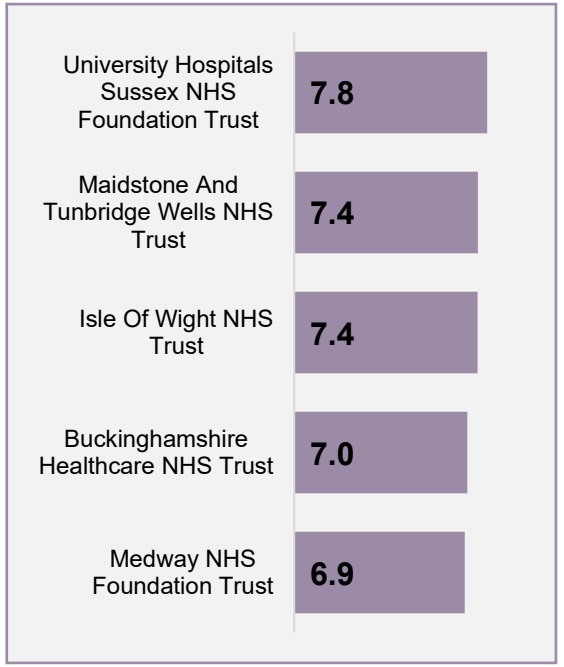
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = - **No section score due to low number of responses**

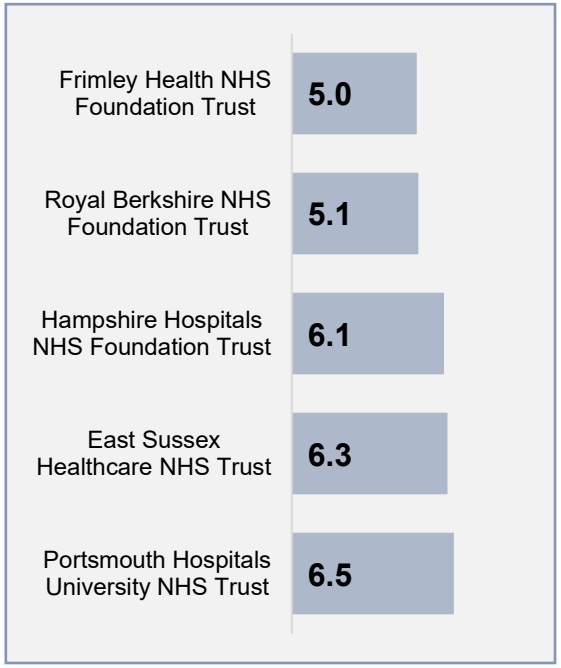


Comparison with other trusts within your region

Trusts with the highest scores

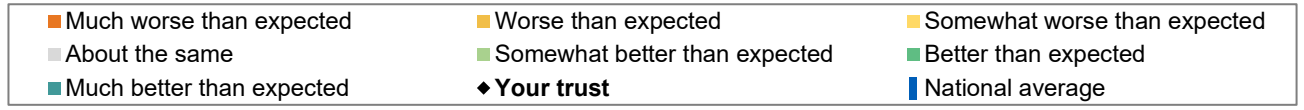


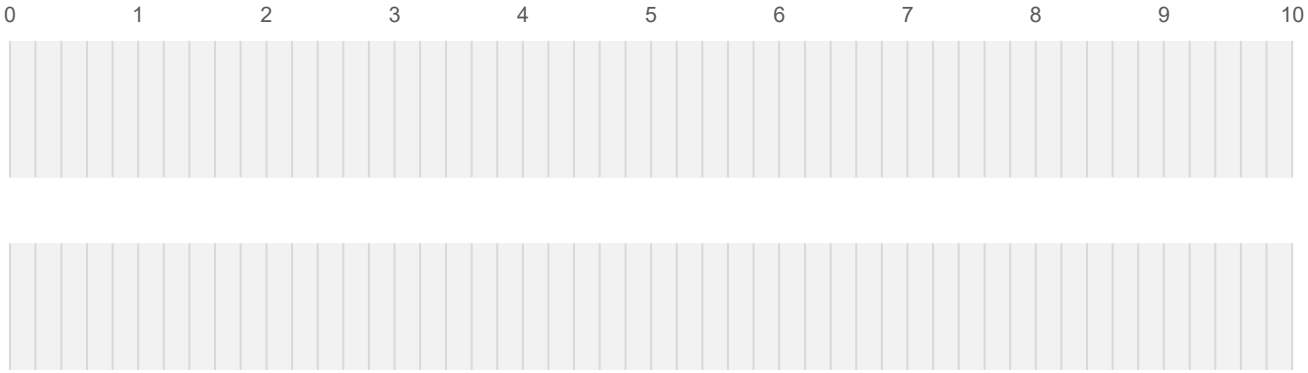
Trusts with the lowest scores



Section 8. Virtual wards (continued)

Question scores





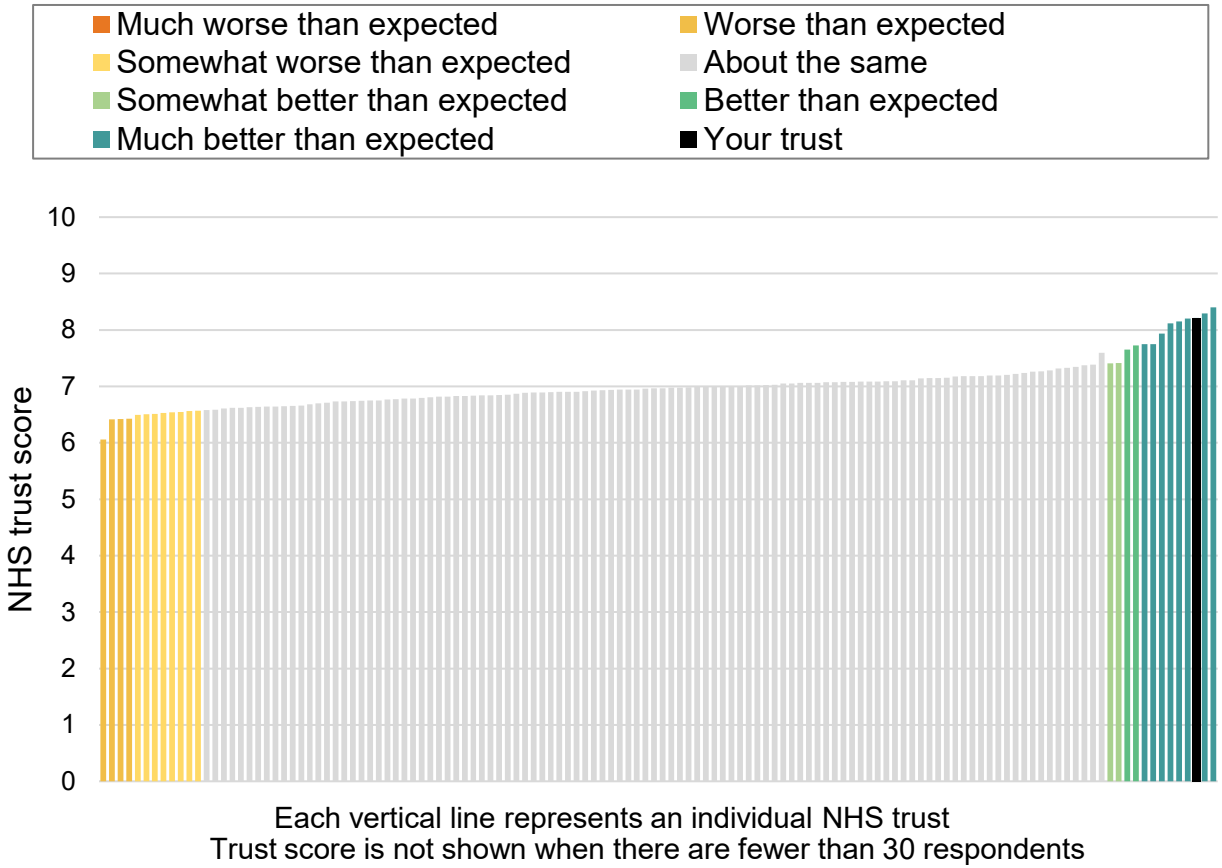
		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Q30. Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?	-	-	6.8	4.6	9.0
Q31. Were you given enough information about the care and treatment you would receive while on a virtual ward?	-	-	7.3	5.3	9.3

Section 9. Leaving hospital

Section score

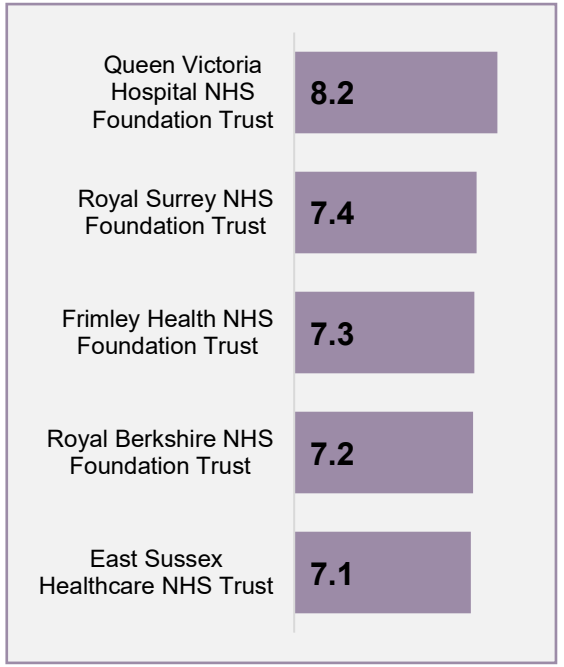
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.2 Much better than expected

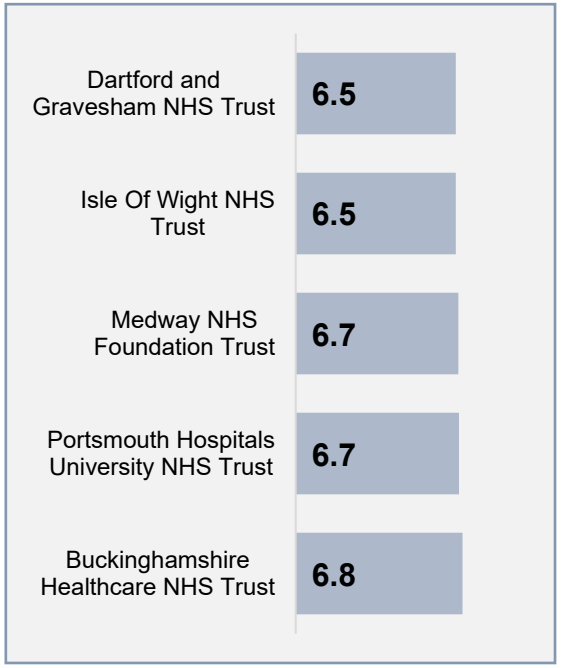


Comparison with other trusts within your region

Trusts with the highest scores

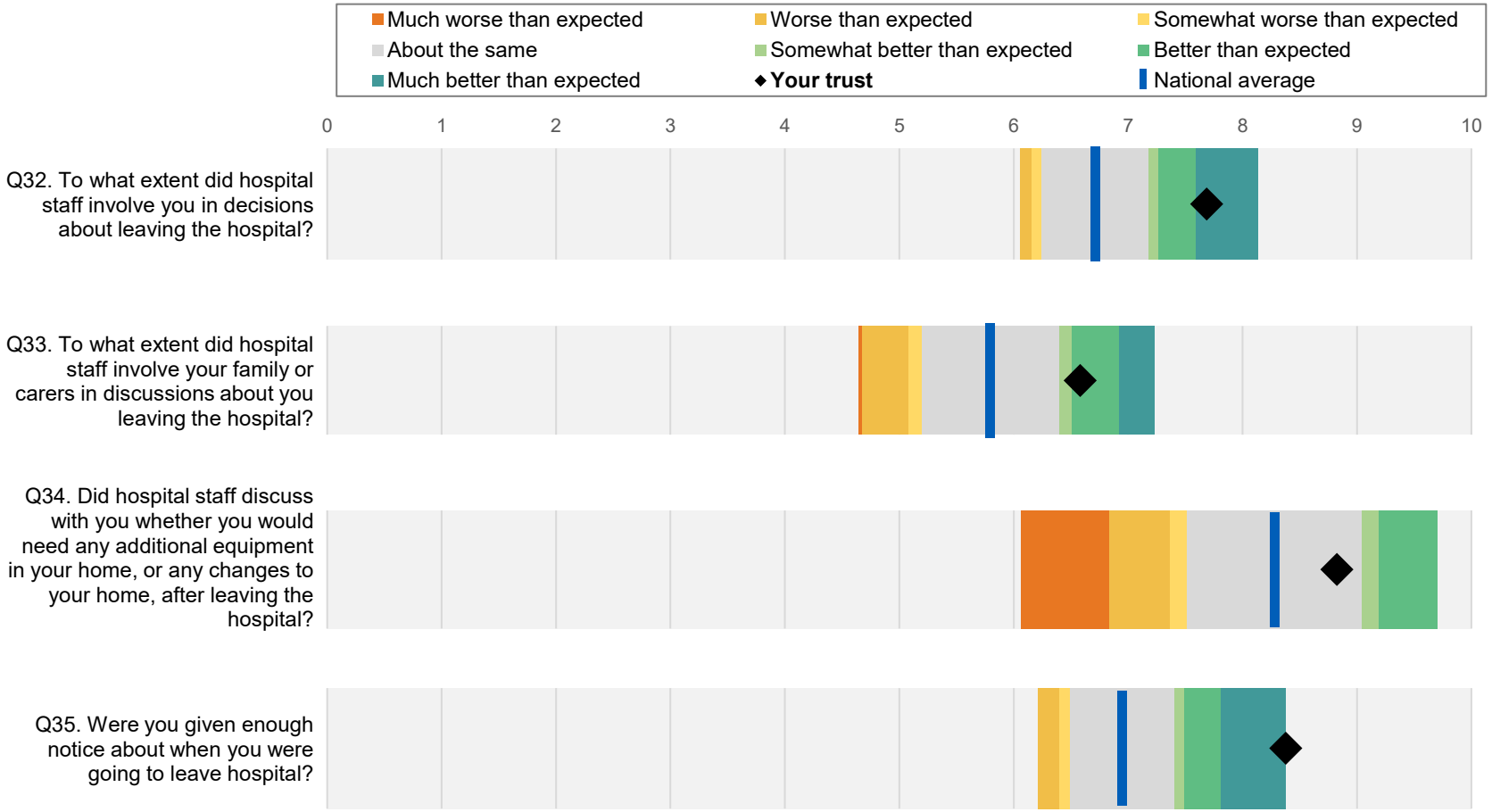


Trusts with the lowest scores



Section 9. Leaving hospital (continued)

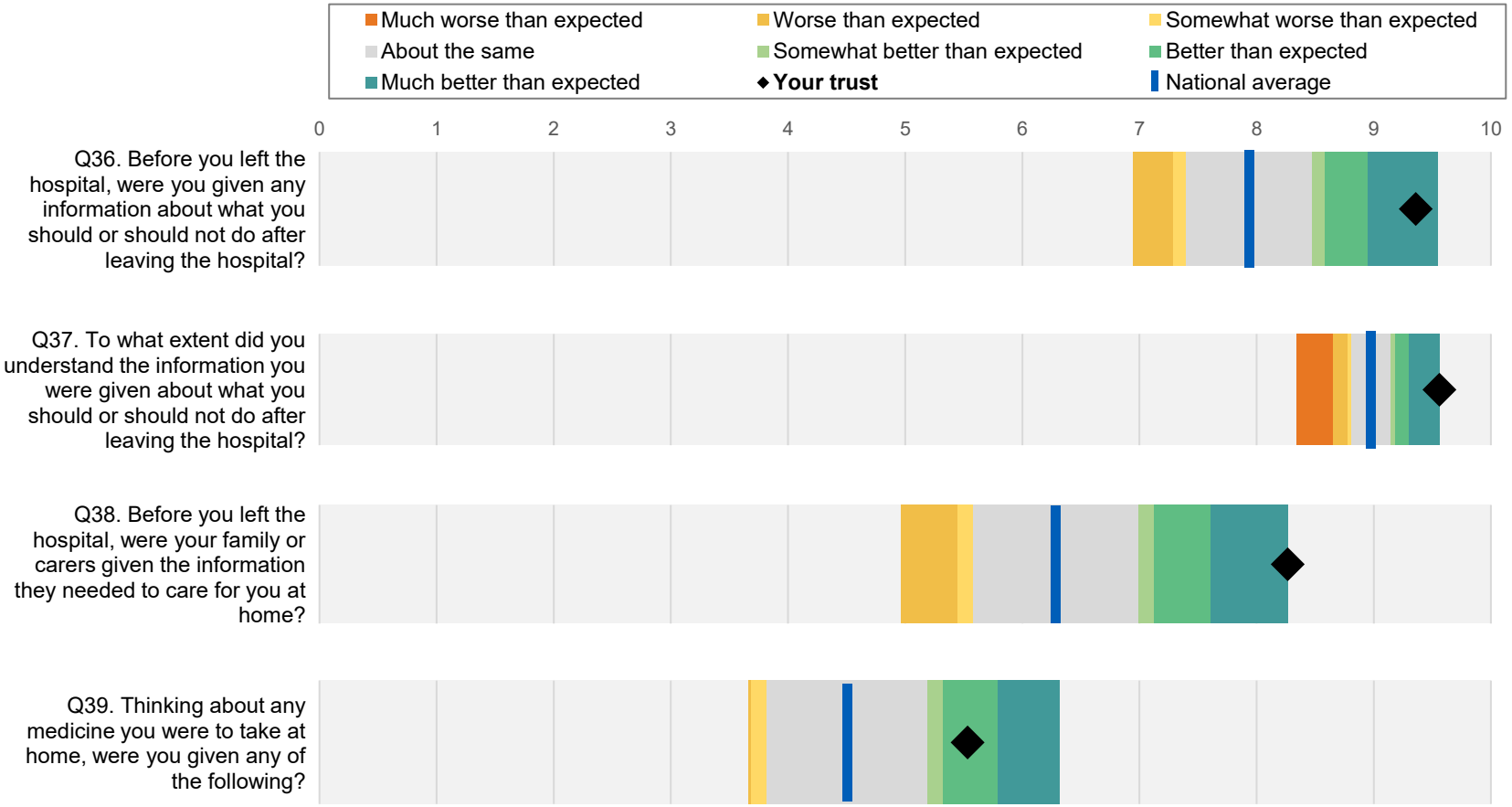
Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
Much better than expected: 461	7.7	6.7	6.1	8.1
Better than expected: 234	6.6	5.8	4.6	7.2
About the same: 77	8.8	8.3	6.1	9.7
Much better than expected: 493	8.4	6.9	6.2	8.4

Section 9. Leaving hospital (continued)

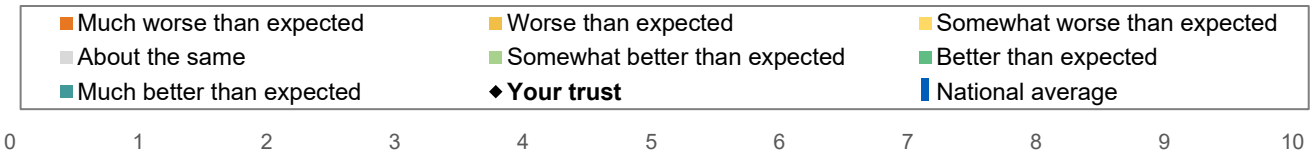
Question scores



			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
Much better than expected	466	9.4	7.9	6.9	9.5
Much better than expected	426	9.6	9.0	8.3	9.6
Much better than expected	212	8.3	6.3	5.0	8.3
Better than expected	275	5.5	4.5	3.7	6.3

Section 9. Leaving hospital (continued)

Question scores



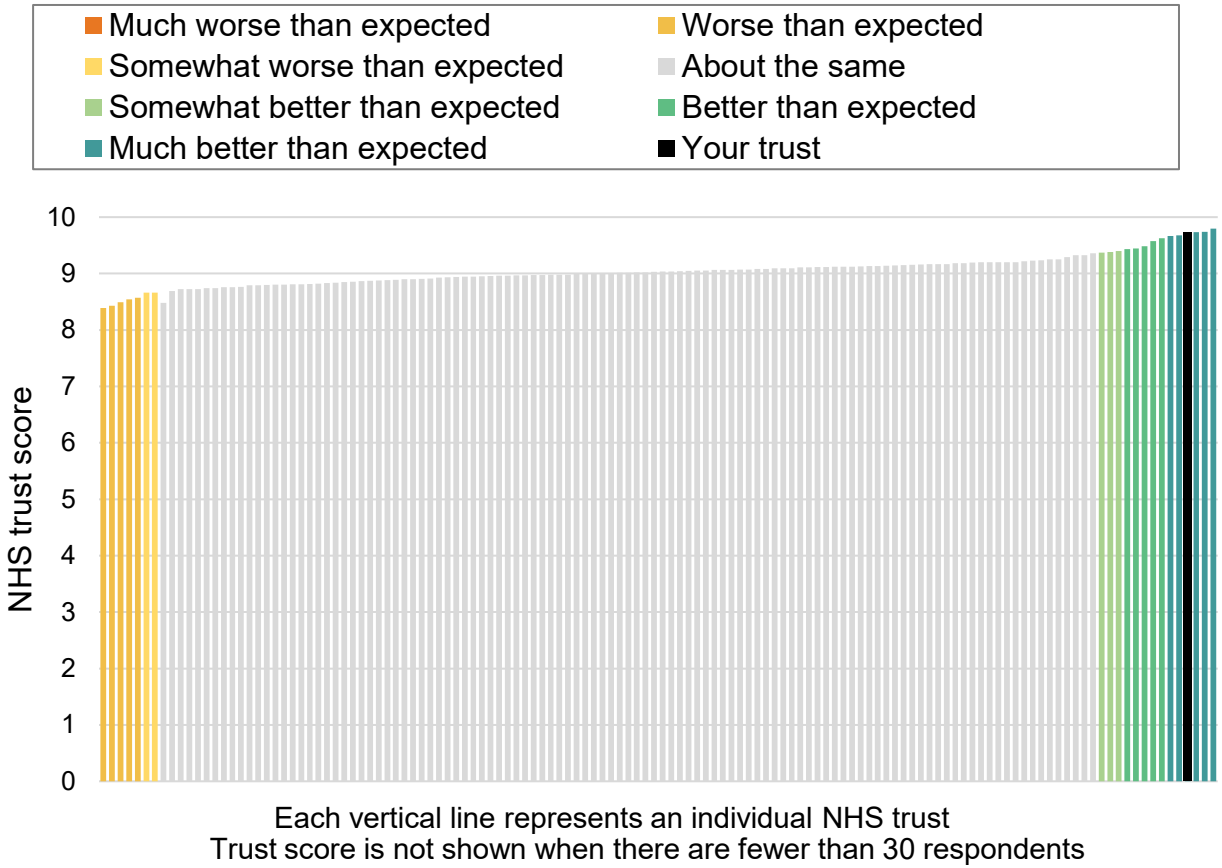
		Number of respondents	Your trust	All trusts in England: National average	All trusts in England: Lowest score	All trusts in England: Highest score
Q40. Before you left the hospital, did you know what would happen next with your care?	Much better than expected	447	8.6	6.7	5.5	8.6
Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	Much better than expected	477	9.3	7.7	6.6	9.9
Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving the hospital?	Much better than expected	163	9.2	8.0	6.0	9.2
Q43. After leaving the hospital, did you get enough support from health or social care services to help you recover or manage your condition?	Better than expected	163	7.3	6.3	3.5	7.8

Section 10. Kindness and compassion

Section score

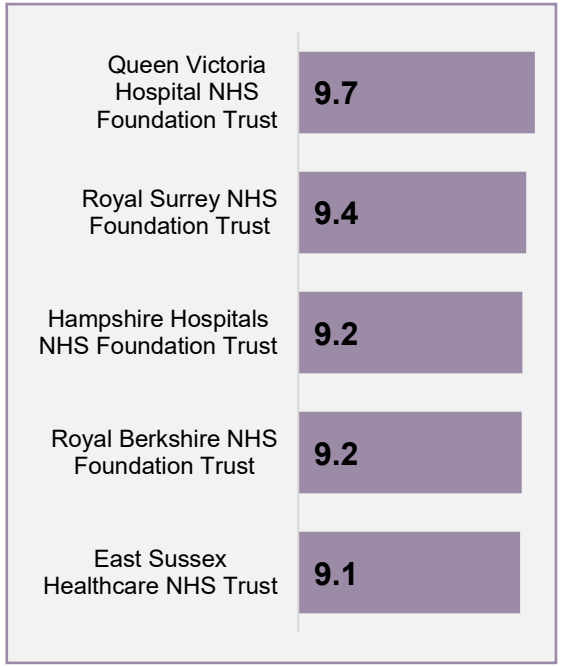
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.7 Much better than expected

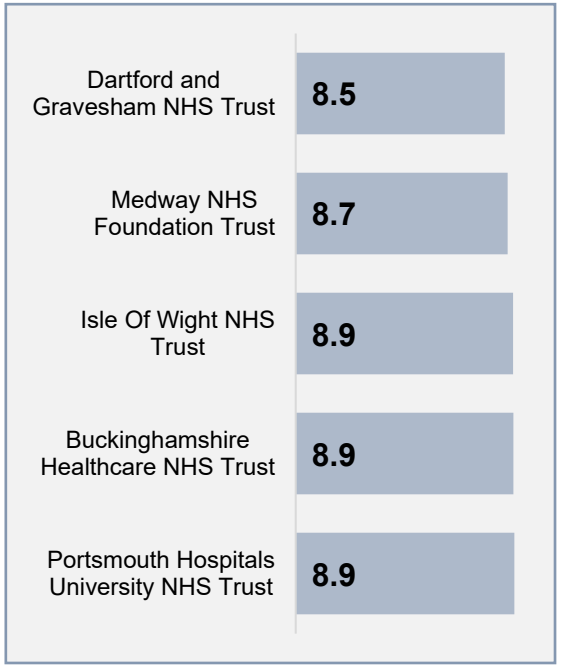


Comparison with other trusts within your region

Trusts with the highest scores

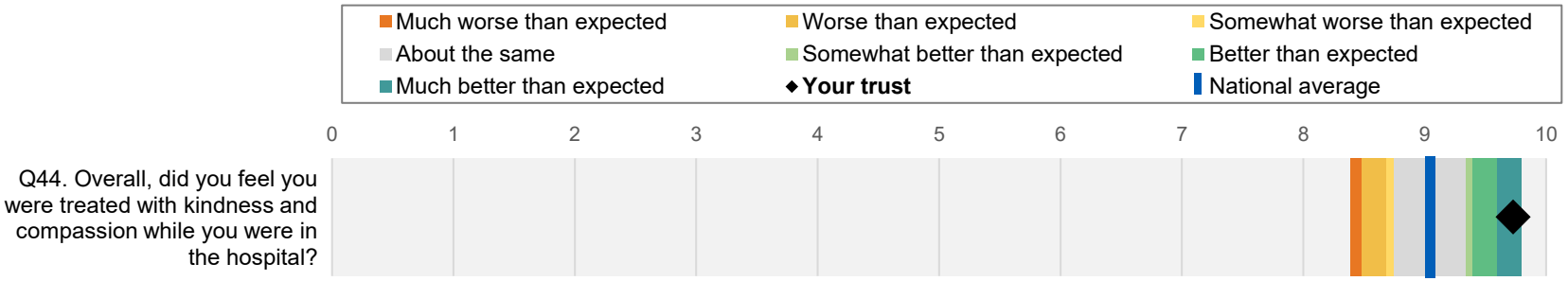


Trusts with the lowest scores



Section 10. Kindness and compassion (continued)

Question score



Much better than expected

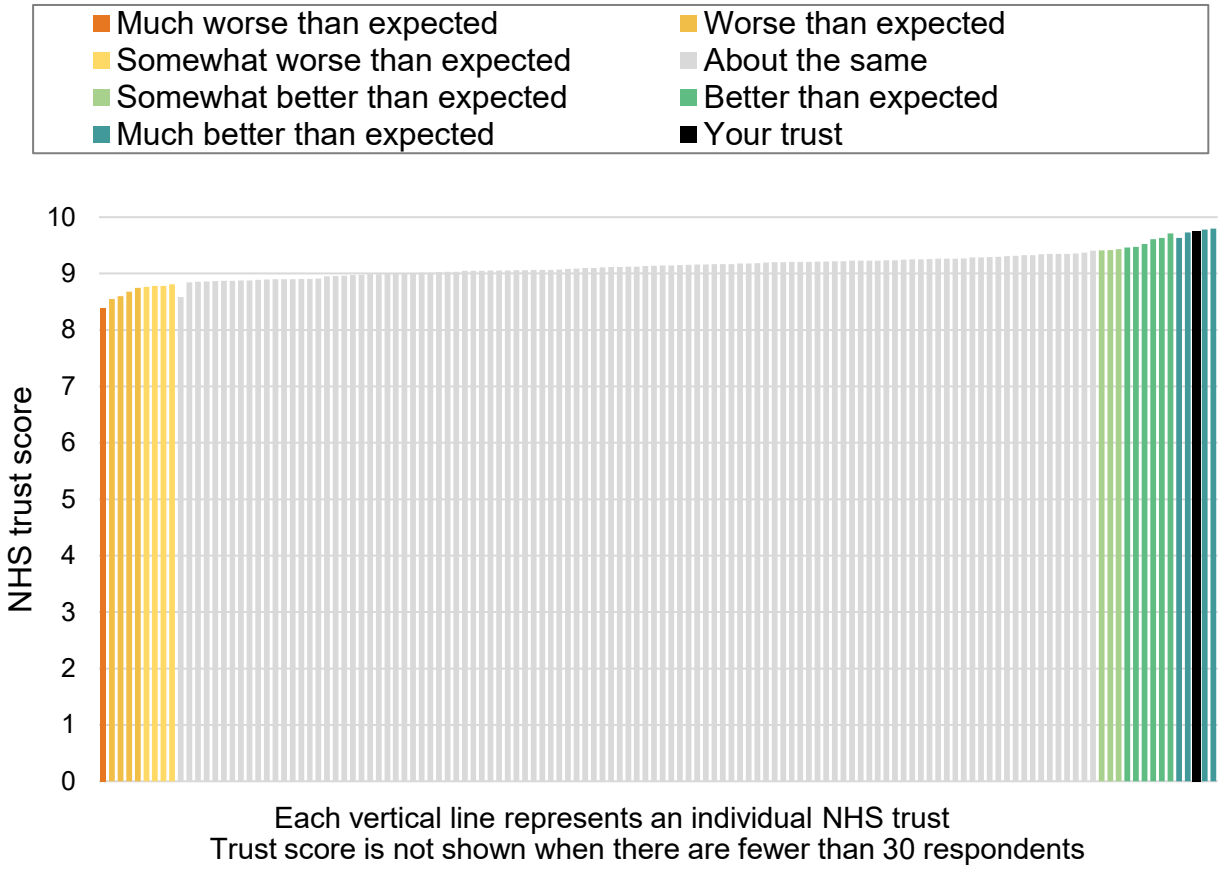
		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
493	9.7	9.0	8.4	9.8

Section 11. Respect and dignity

Section score

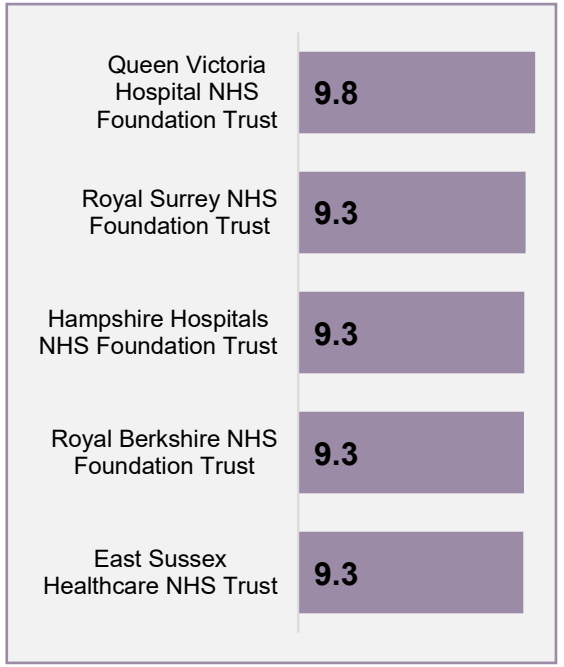
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.8 Much better than expected

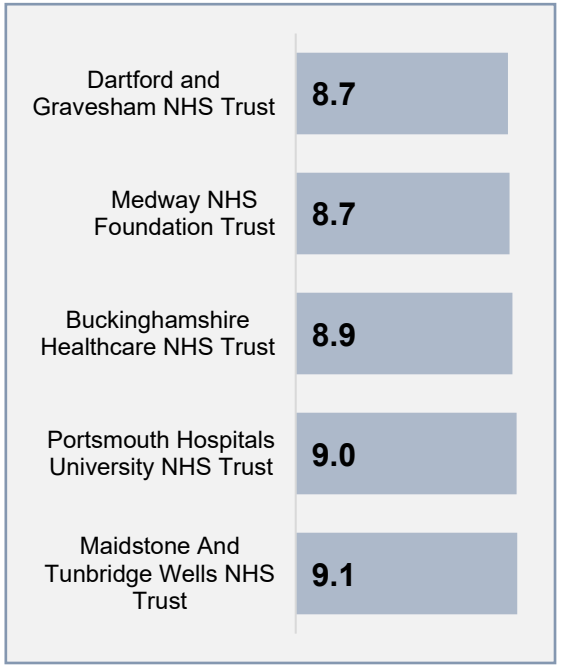


Comparison with other trusts within your region

Trusts with the highest scores

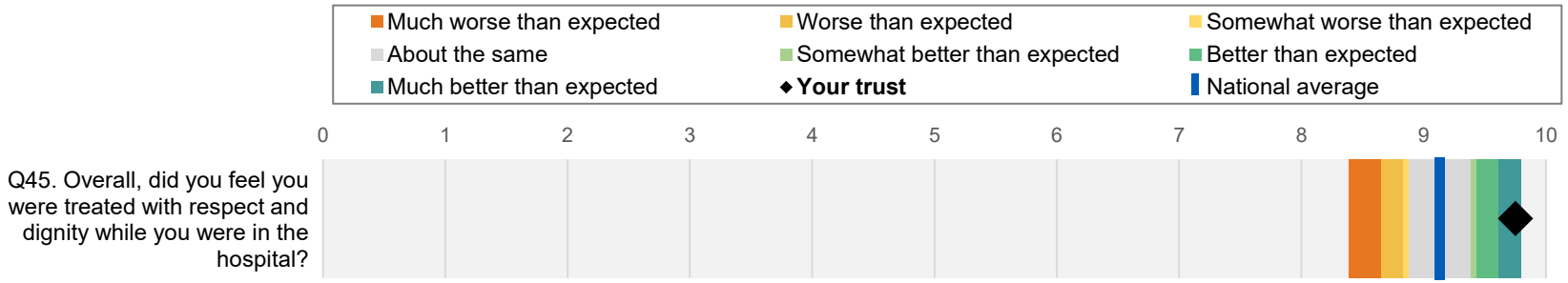


Trusts with the lowest scores



Section 11. Respect and dignity (continued)

Question score



Much better than expected

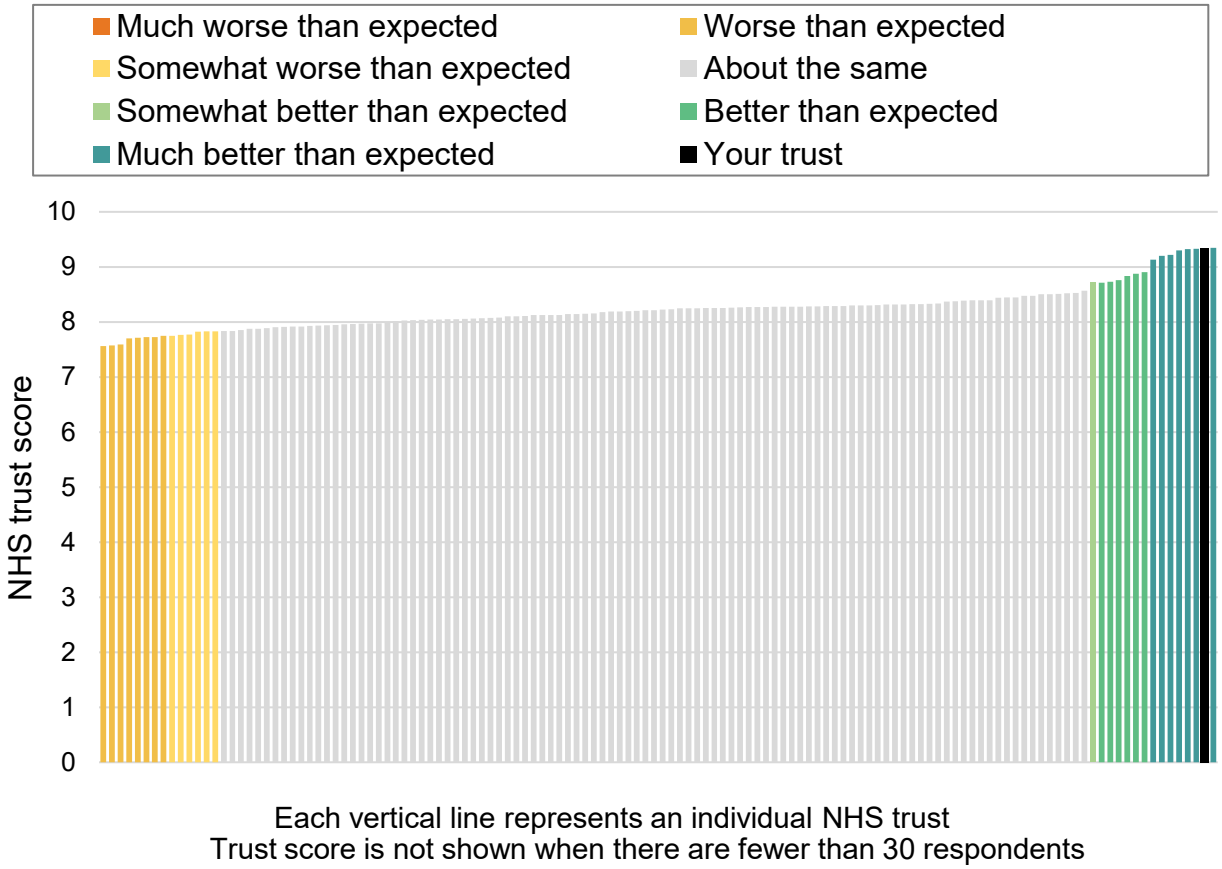
		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
491	9.8	9.1	8.4	9.8

Section 12. Overall experience

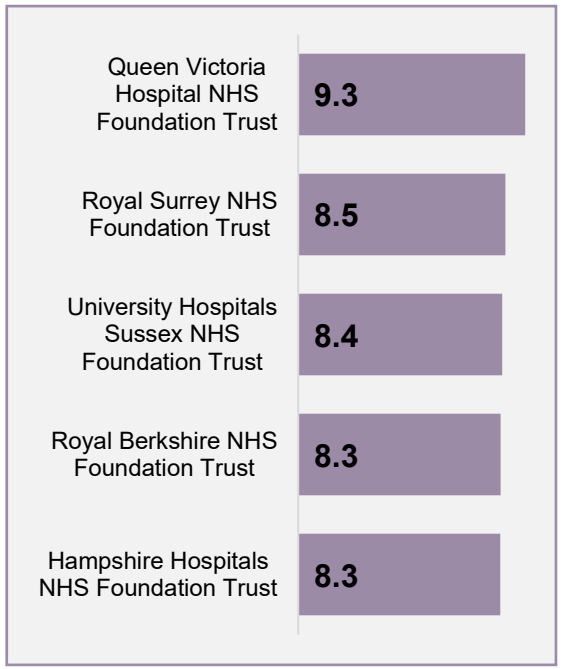
Section score

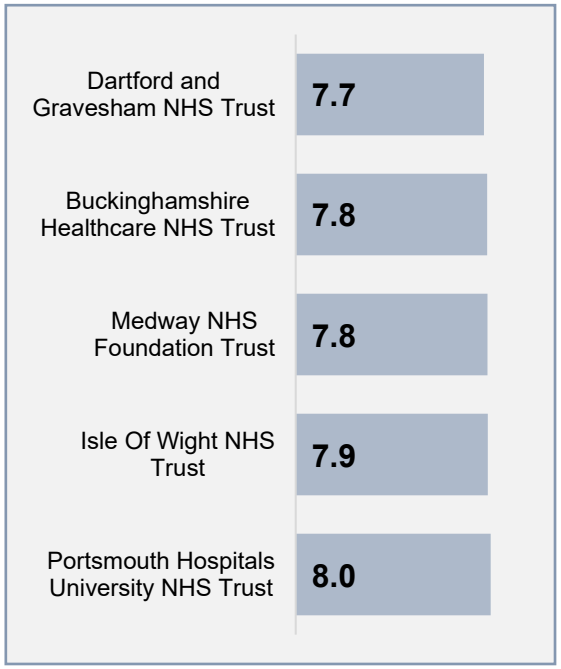
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 9.3 Much better than expected



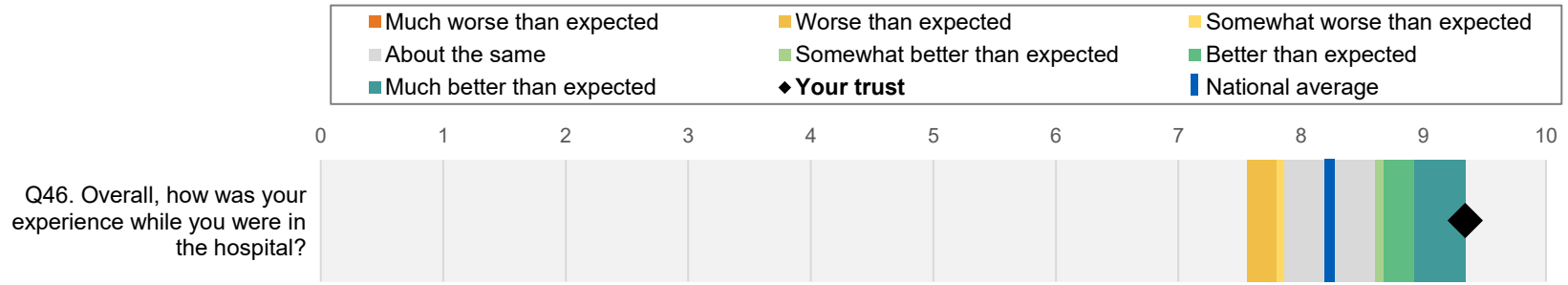
Comparison with other trusts within your region





Section 12. Overall experience (continued)

Question score



Much better than expected

		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
493	9.3	8.2	7.6	9.3

Trust and site results

This section includes:

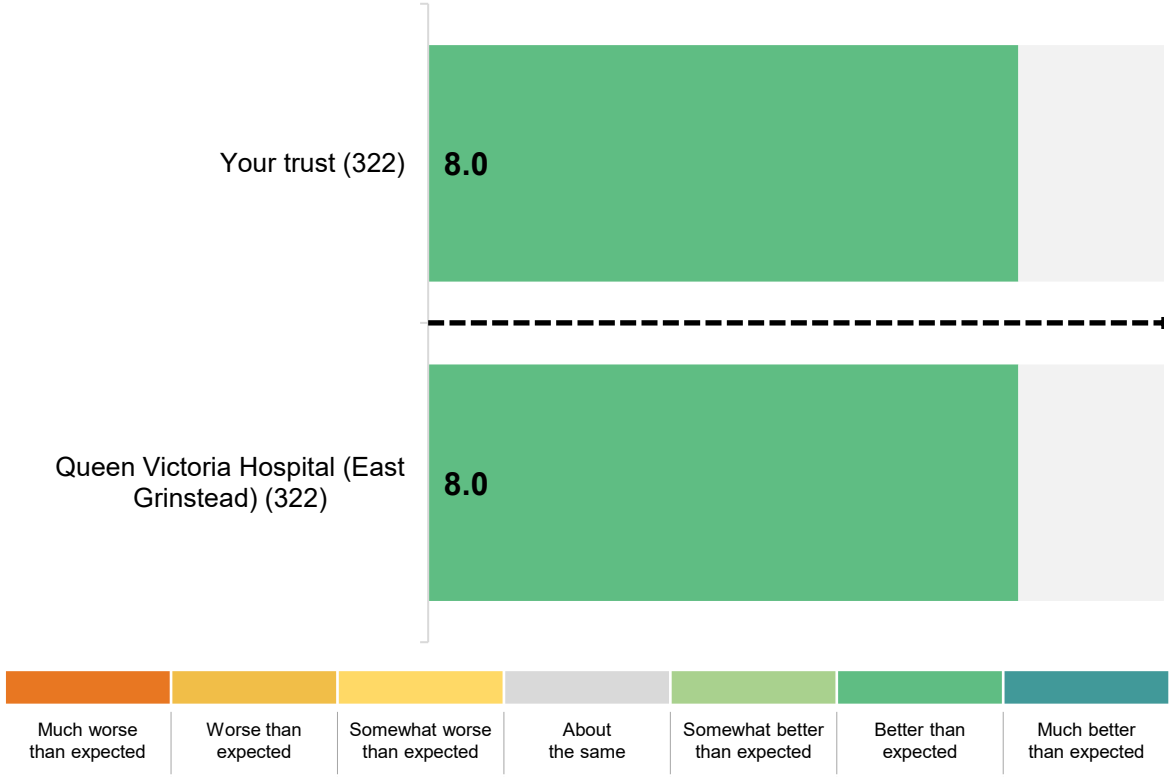
- an overview of results for your trust for each question, including:
  - the score for your trust
  - a breakdown of scores across sites within your trust
- if fewer than 30 responses were received from patients discharged from a site, no scores will be displayed for that site

Section 1. Admission to hospital

Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



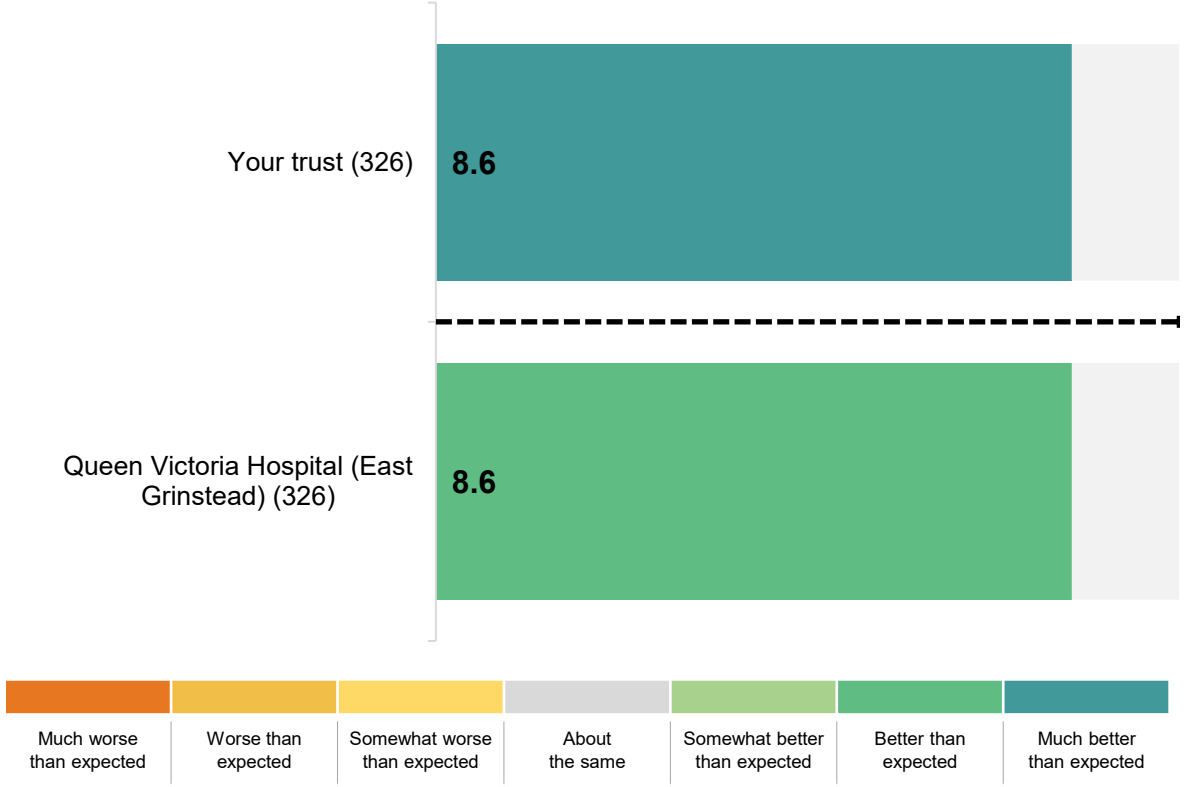
Please note: the number of respondents is shown in brackets next to the site name

Section 1. Admission to hospital

Q4. How would you rate the quality of information you were given, while you were on the waiting list to be admitted to hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



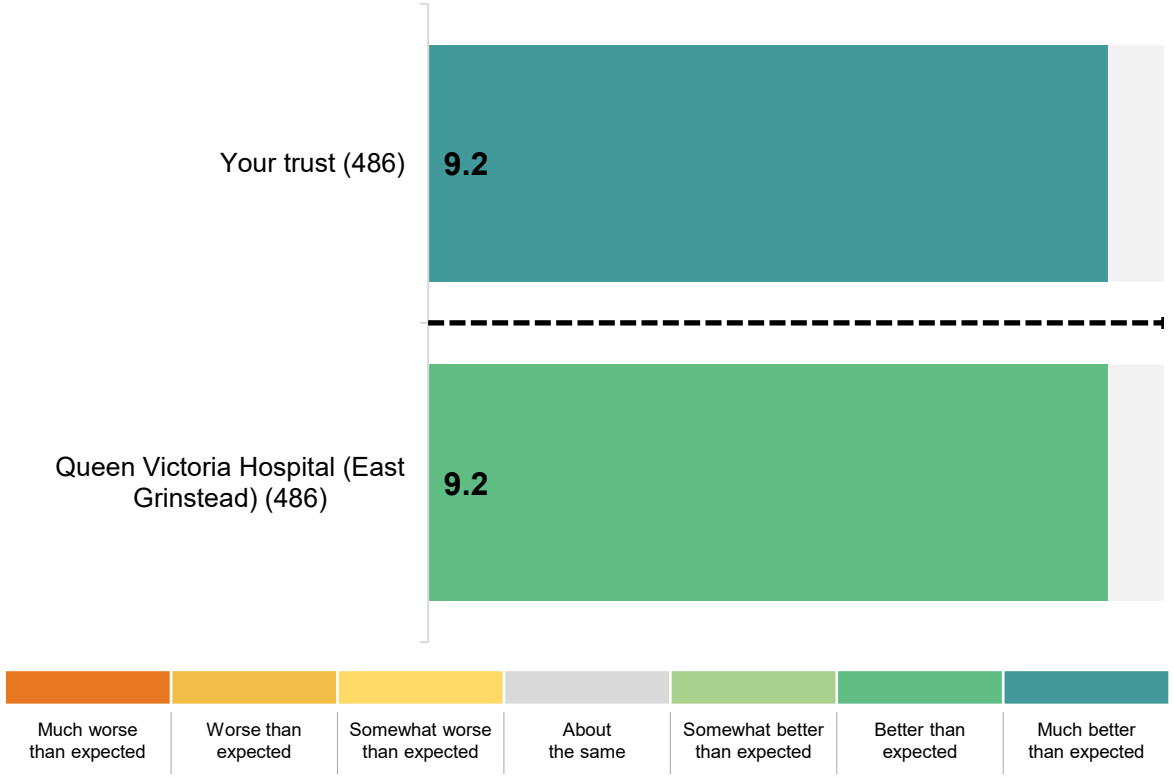
Please note: the number of respondents is shown in brackets next to the site name

Section 1. Admission to hospital

Q5. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



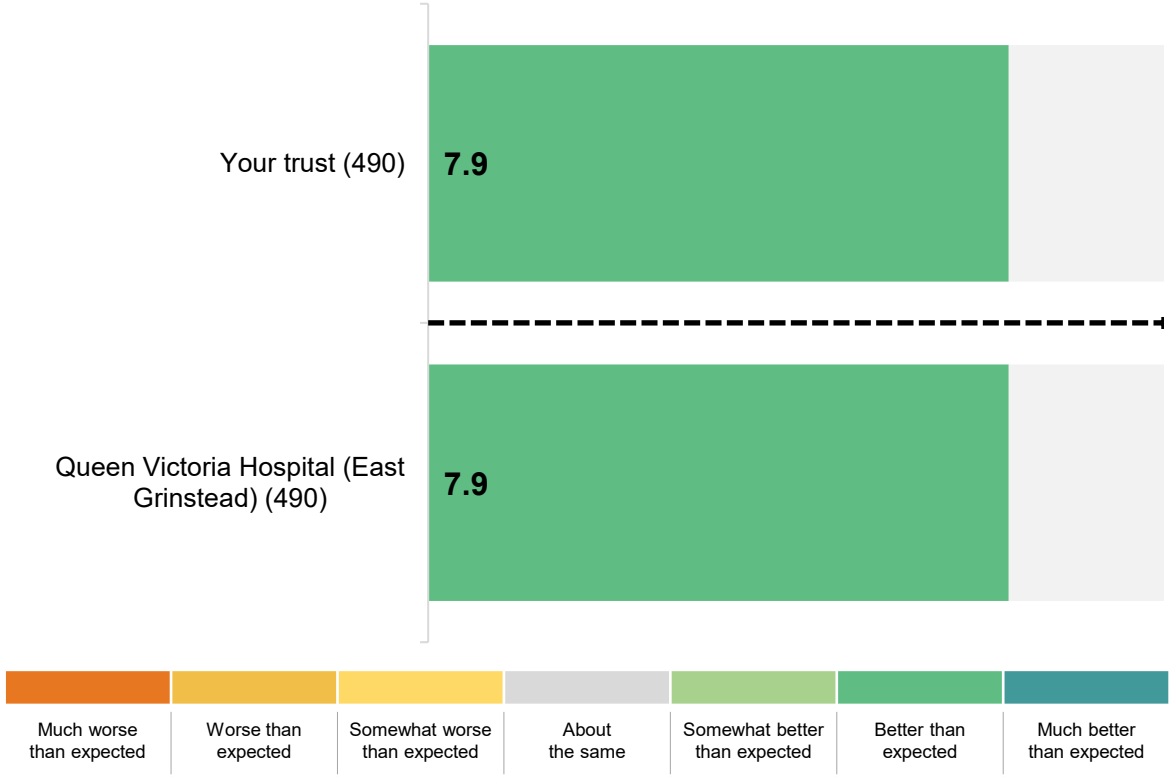
Please note: the number of respondents is shown in brackets next to the site name

Section 2. The hospital and ward

Q7_1. Were you ever prevented from sleeping at night by noise from other patients?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



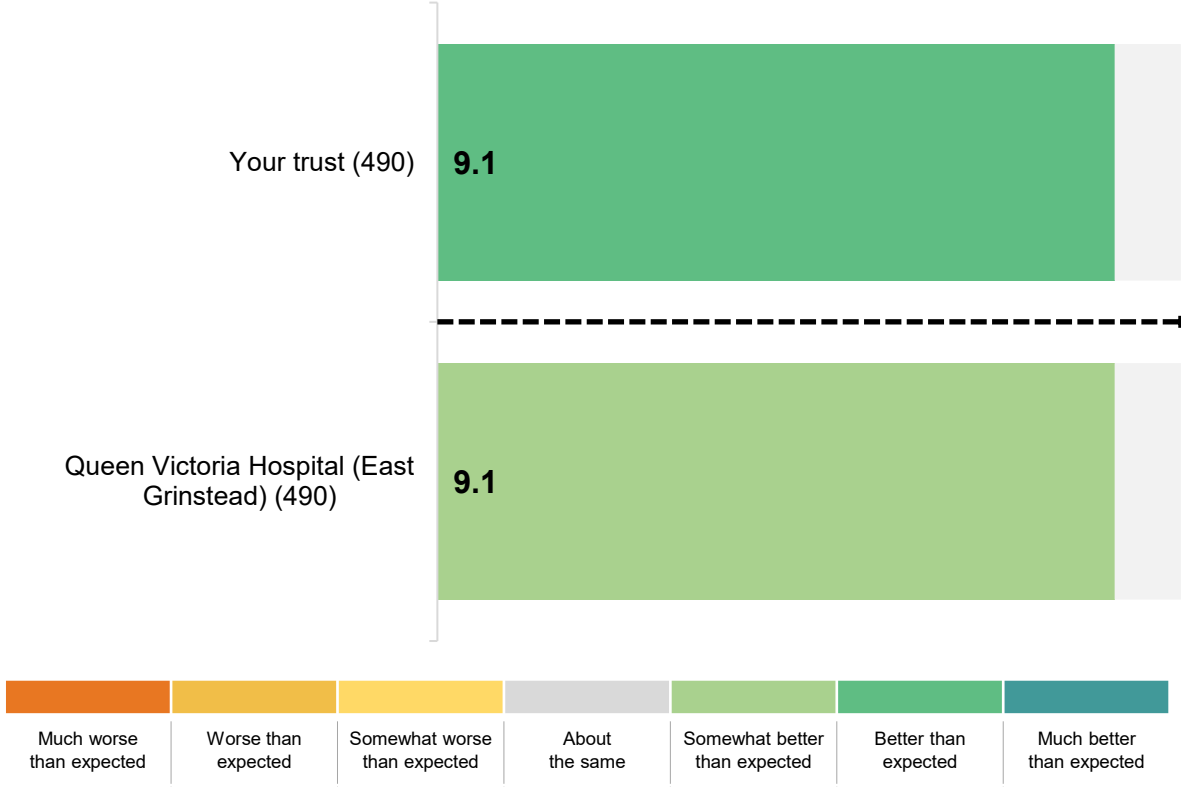
Please note: the number of respondents is shown in brackets next to the site name

Section 2. The hospital and ward

Q7_2. Were you ever prevented from sleeping at night by noise from staff?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



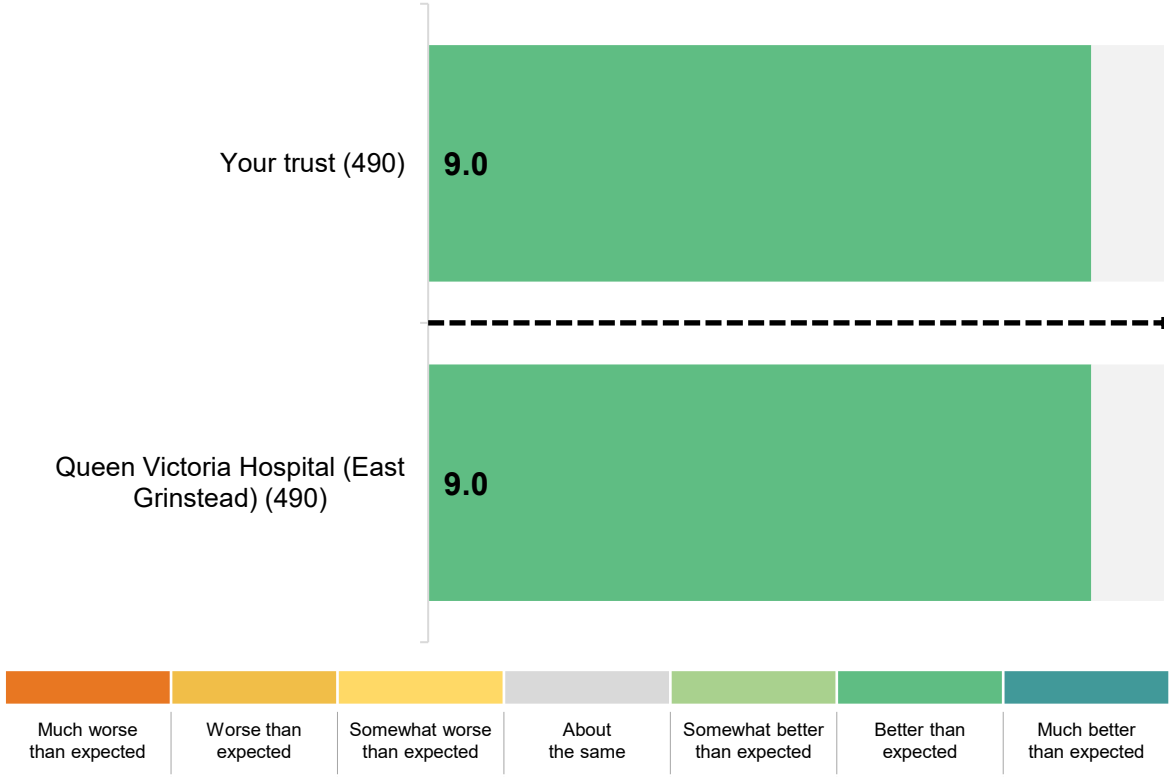
Please note: the number of respondents is shown in brackets next to the site name

Section 2. The hospital and ward

Q7_4. Were you ever prevented from sleeping at night by hospital lighting?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



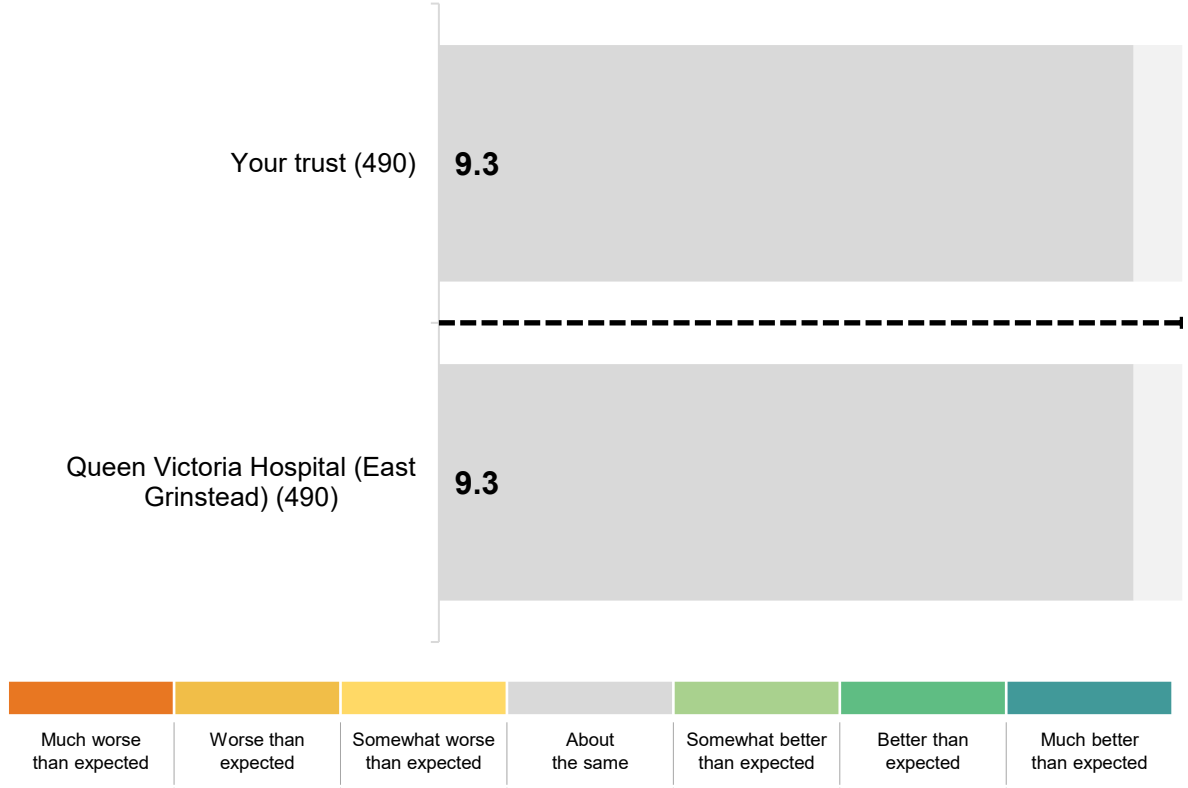
Please note: the number of respondents is shown in brackets next to the site name

Section 2. The hospital and ward

Q7_6. Were you ever prevented from sleeping at night by the room temperature?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



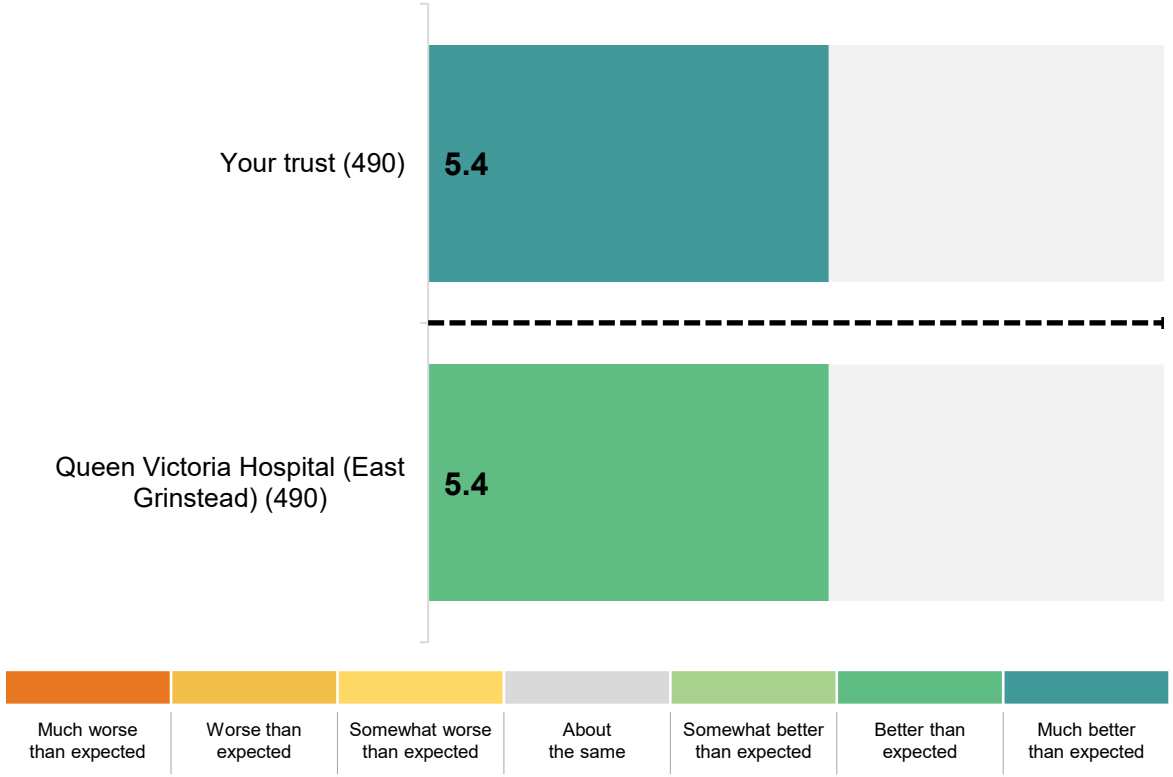
Please note: the number of respondents is shown in brackets next to the site name

Section 2. The hospital and ward

Q7_8. Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



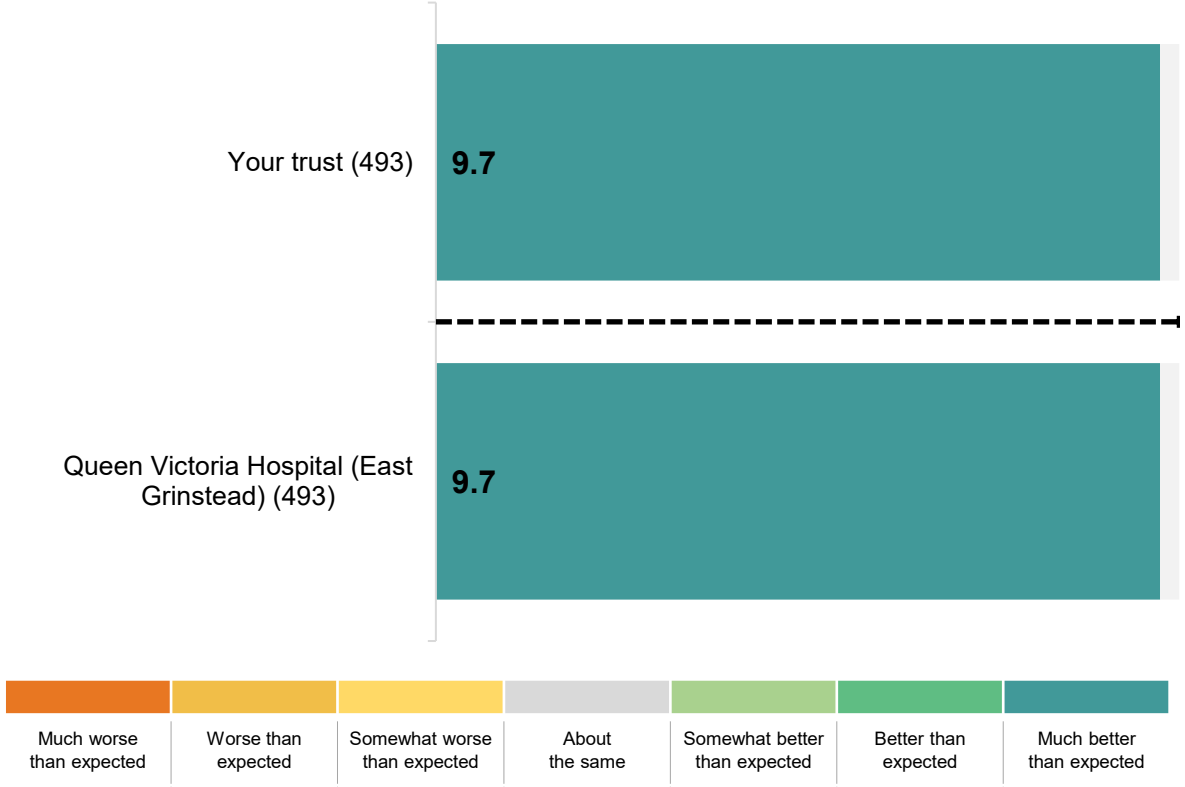
Please note: the number of respondents is shown in brackets next to the site name

Section 2. The hospital and ward

Q8. How clean was the hospital room or ward that you were in?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



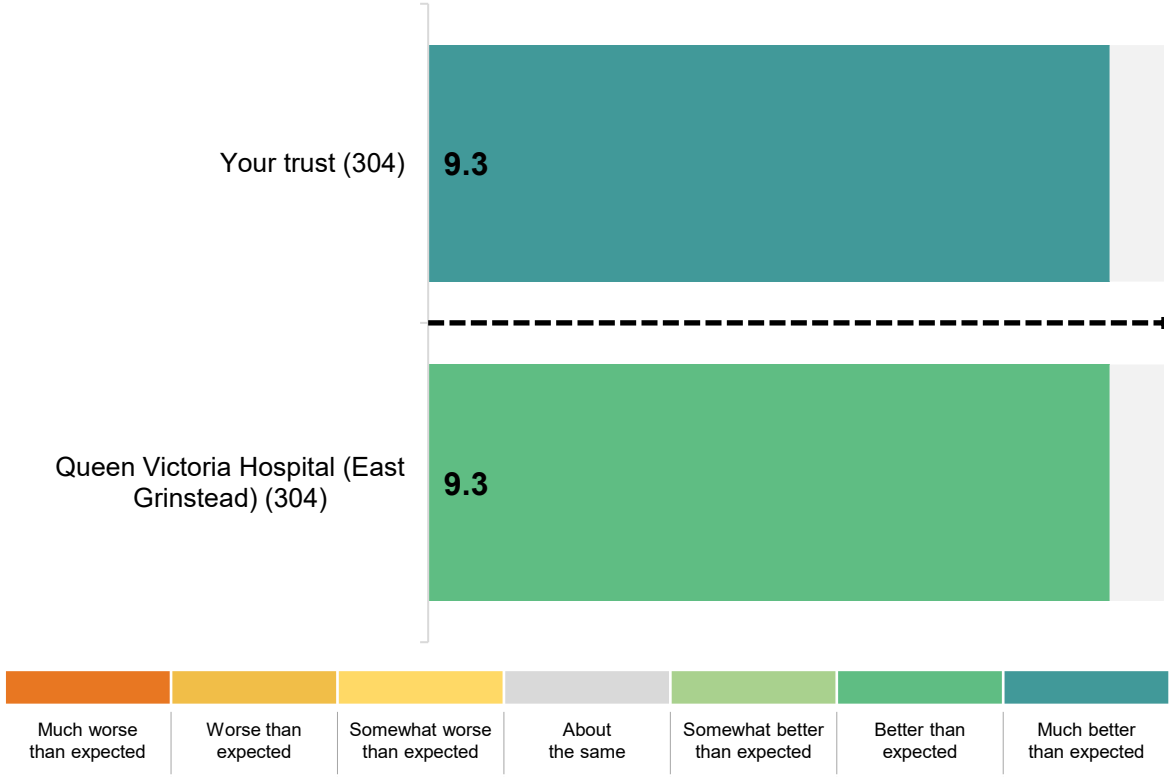
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Basic needs

Q9. Did you get enough help from staff to wash or keep yourself clean?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



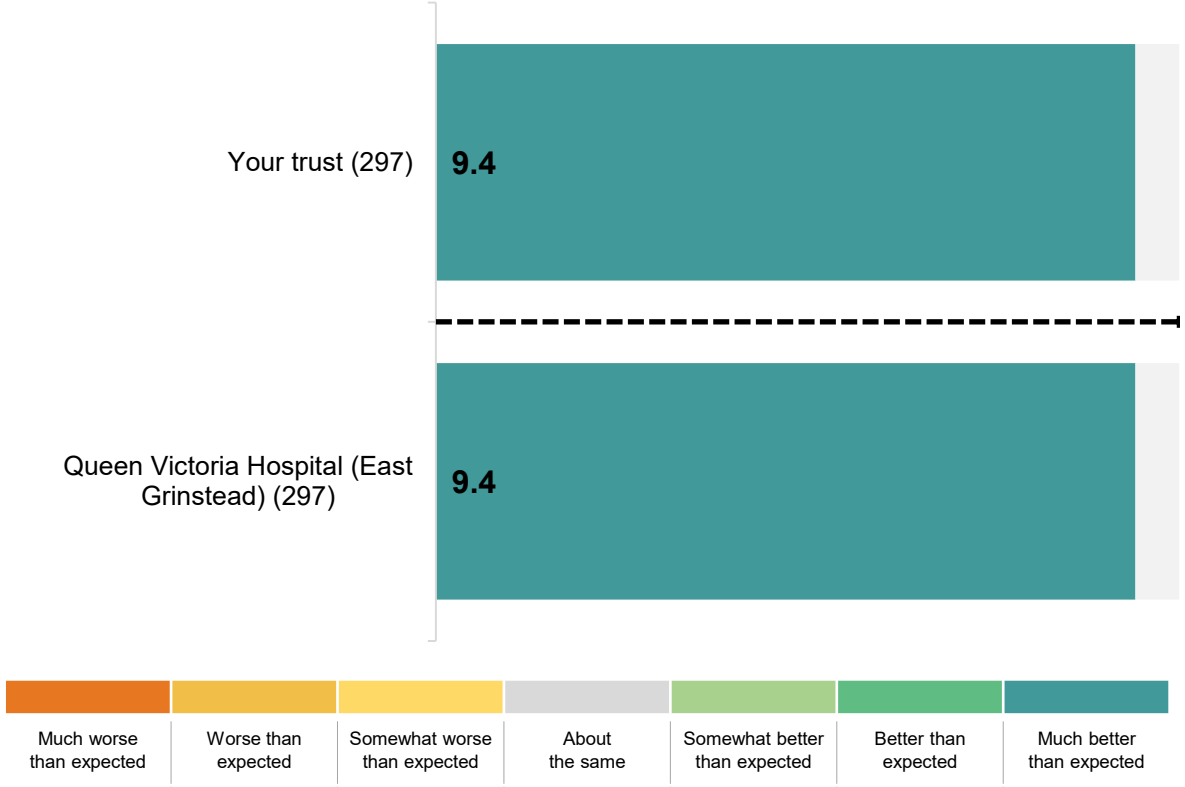
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Basic needs

Q10. If you brought medication with you to hospital, were you able to take it when you needed to?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



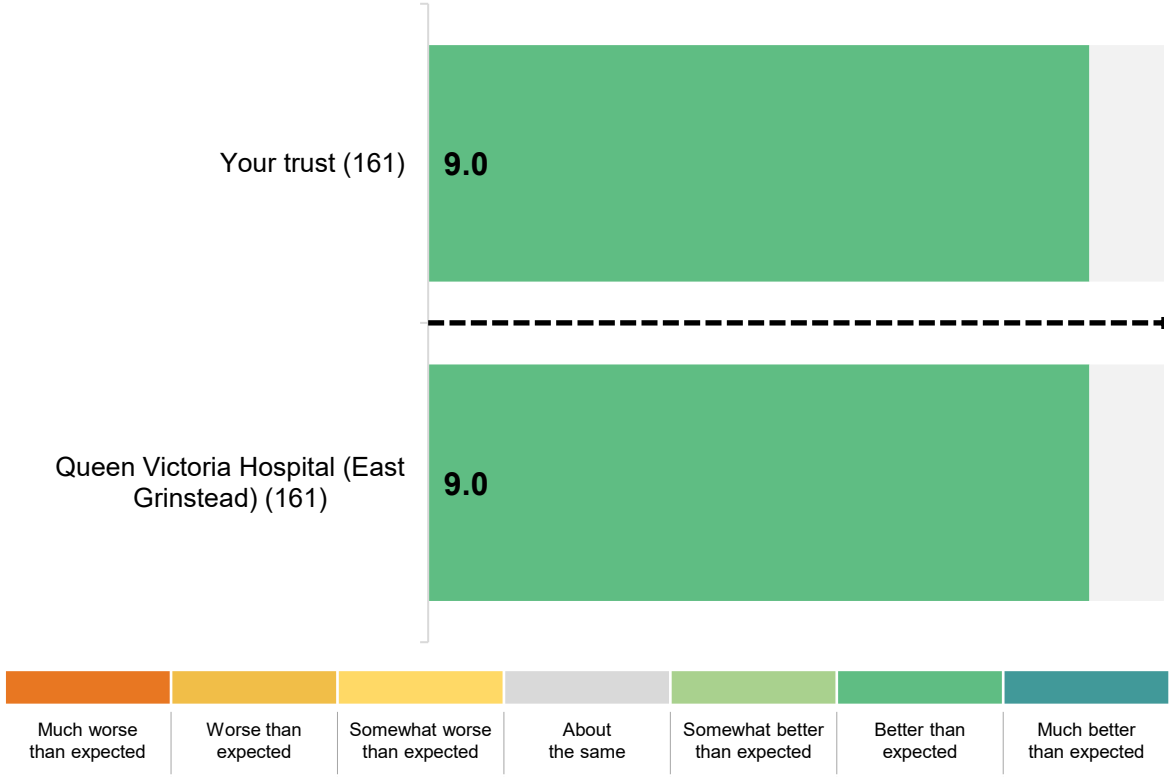
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Basic needs

Q11. Did you get enough help from staff to eat your meals?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



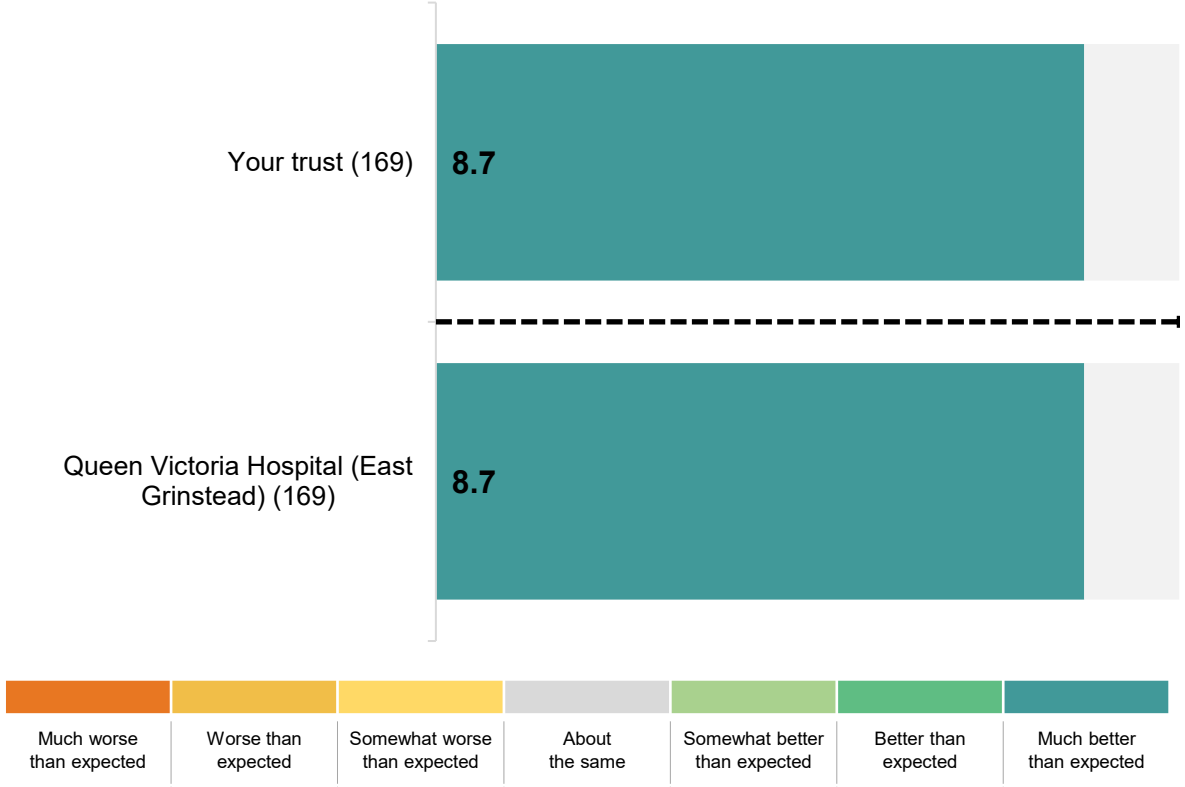
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Basic needs

Q12. Were you able to get hospital food outside of set mealtimes?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



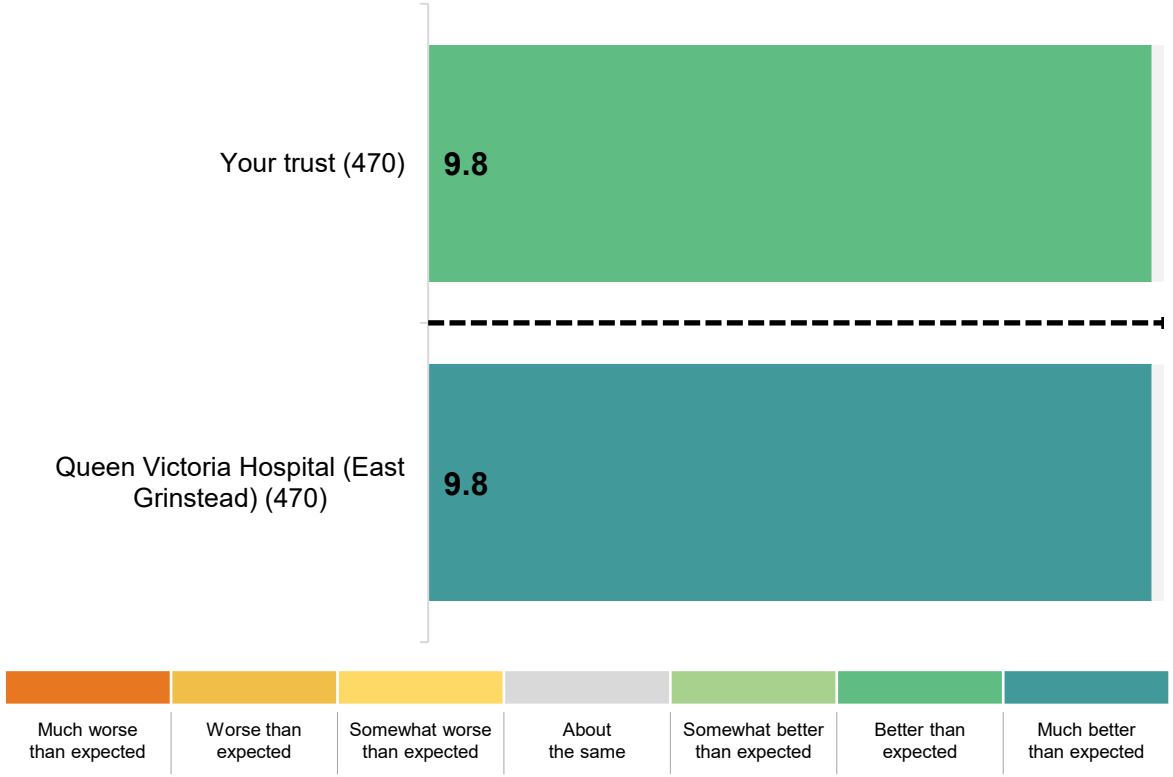
Please note: the number of respondents is shown in brackets next to the site name

Section 3. Basic needs

Q13. During your time in hospital, did you get enough to drink?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



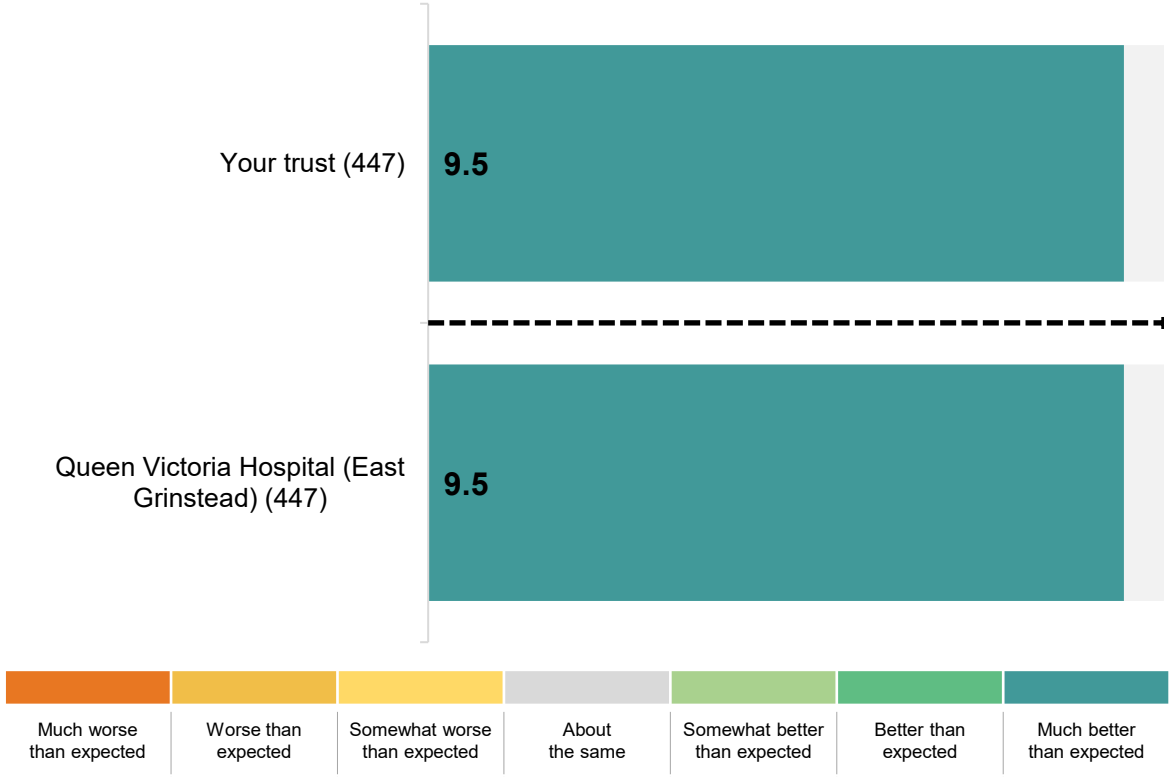
Please note: the number of respondents is shown in brackets next to the site name

Section 4. Doctors

Q14. When you asked doctors questions, did you get answers you could understand?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



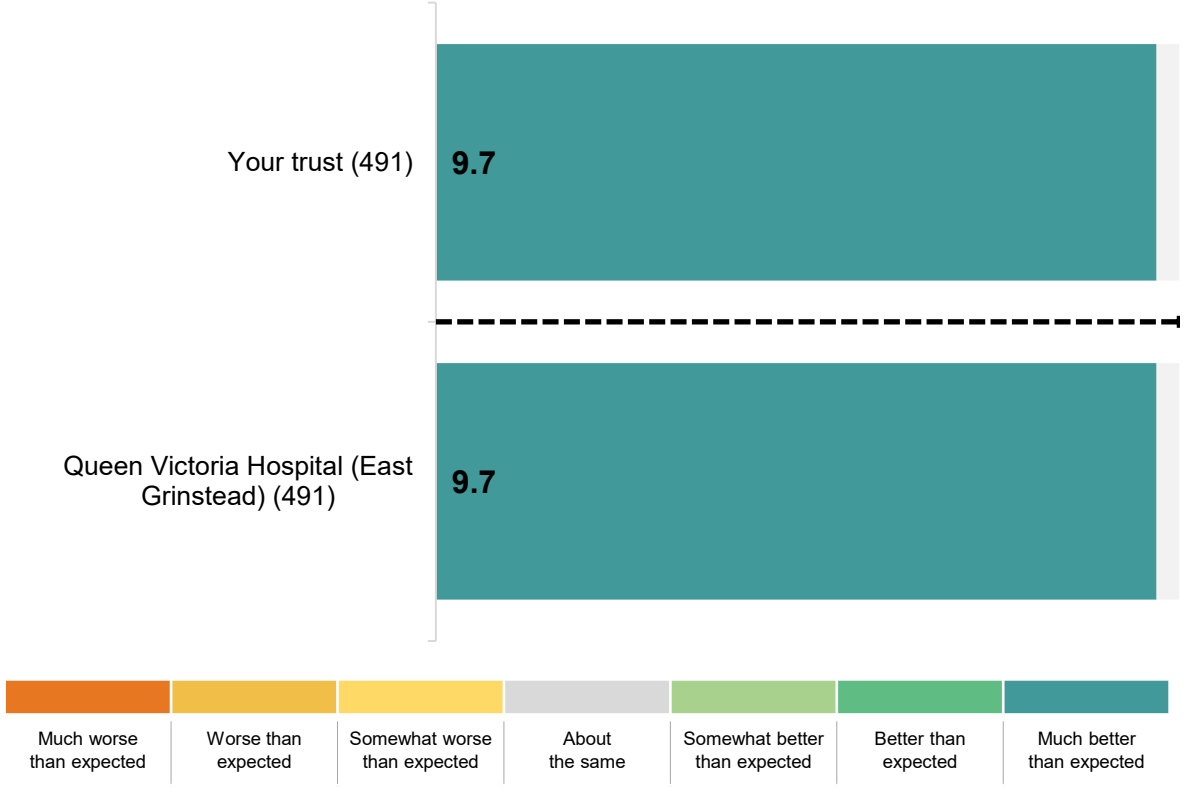
Please note: the number of respondents is shown in brackets next to the site name

Section 4. Doctors

Q15. Did you have confidence and trust in the doctors treating you?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



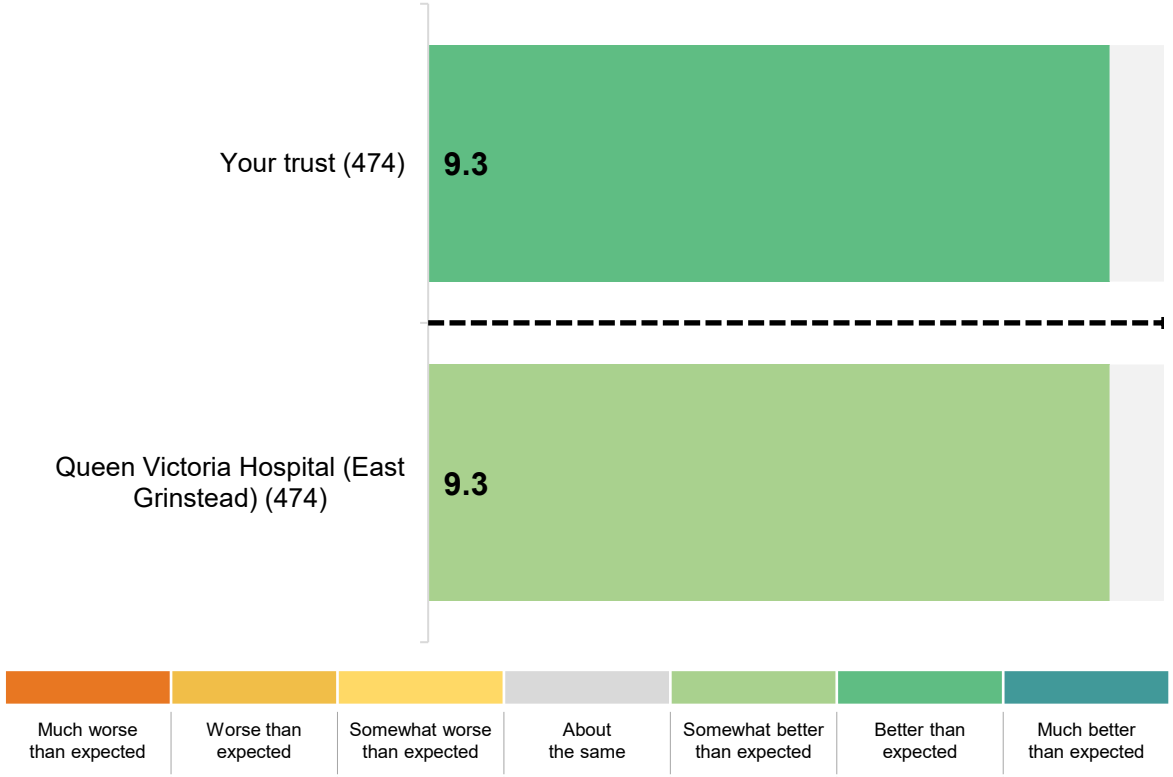
Please note: the number of respondents is shown in brackets next to the site name

Section 4. Doctors

Q16. When doctors spoke about your care in front of you, were you included in the conversation?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



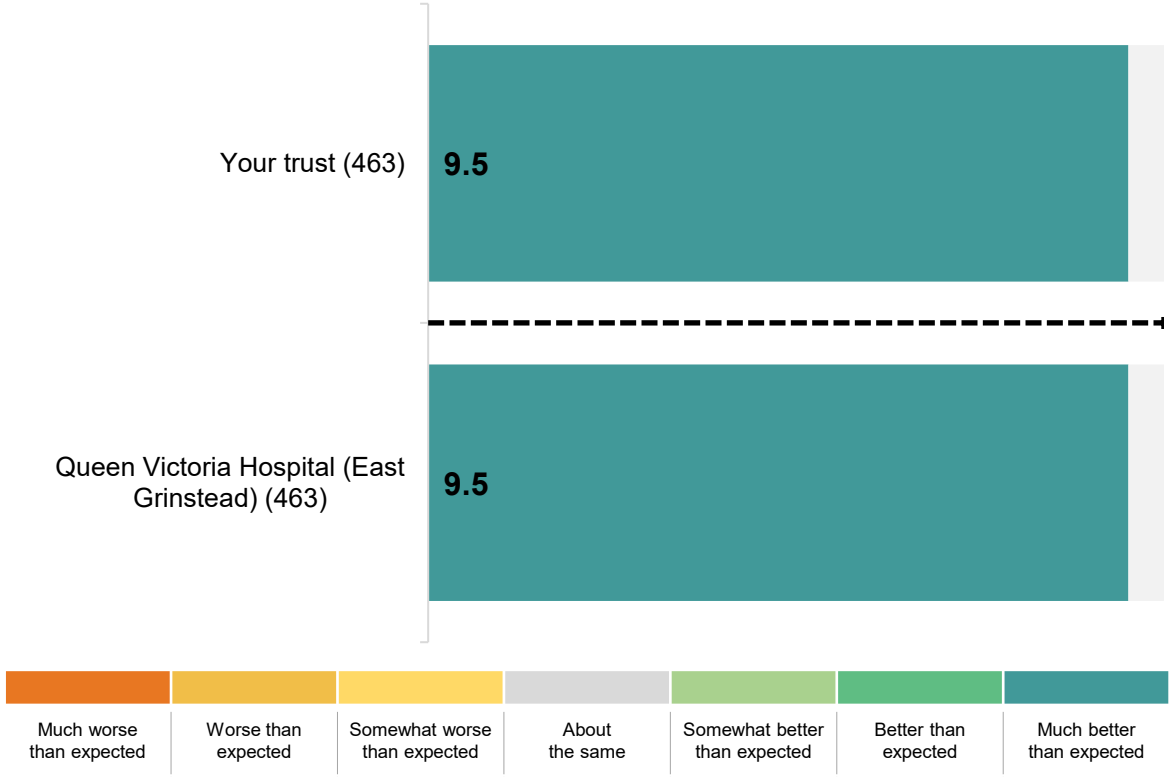
Please note: the number of respondents is shown in brackets next to the site name

Section 5. Nurses

Q17. When you asked nurses questions, did you get answers you could understand?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



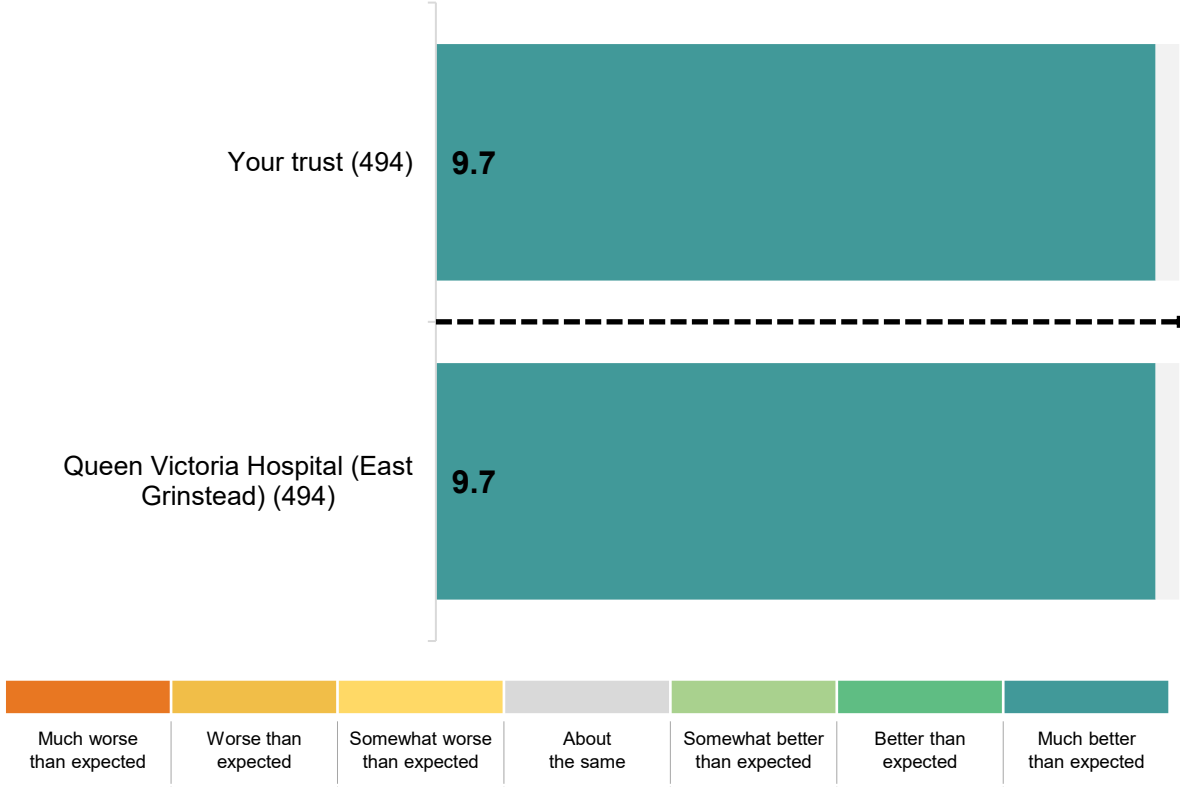
Please note: the number of respondents is shown in brackets next to the site name

Section 5. Nurses

Q18. Did you have confidence and trust in the nurses treating you?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



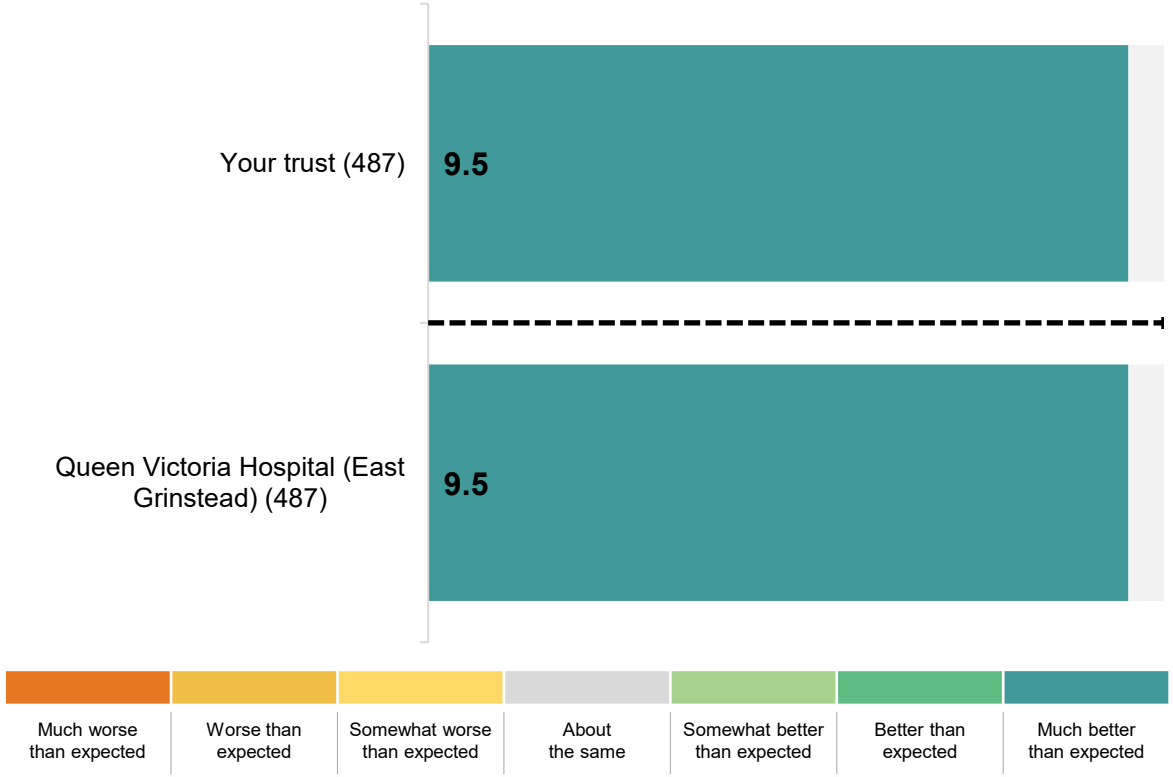
Please note: the number of respondents is shown in brackets next to the site name

Section 5. Nurses

Q19. When nurses spoke about your care in front of you, were you included in the conversation?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



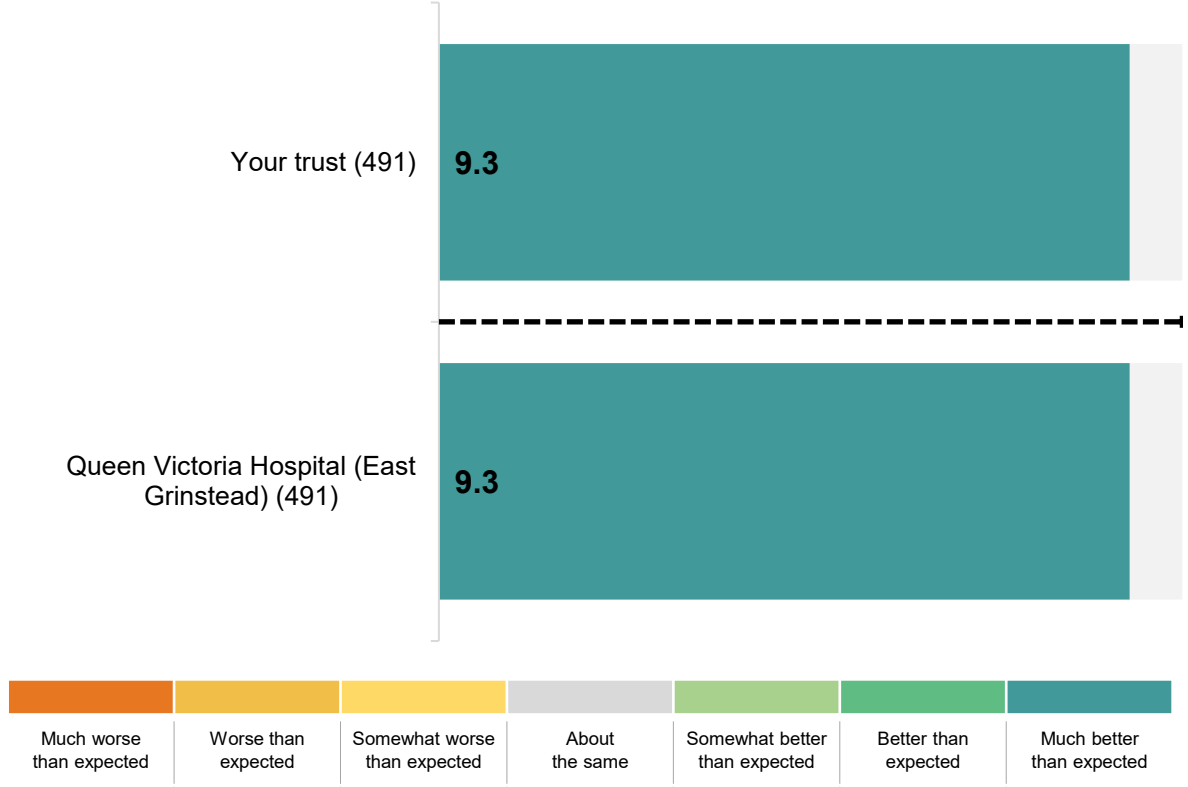
Please note: the number of respondents is shown in brackets next to the site name

Section 5. Nurses

Q20. In your opinion, were there enough nurses on duty to care for you in hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



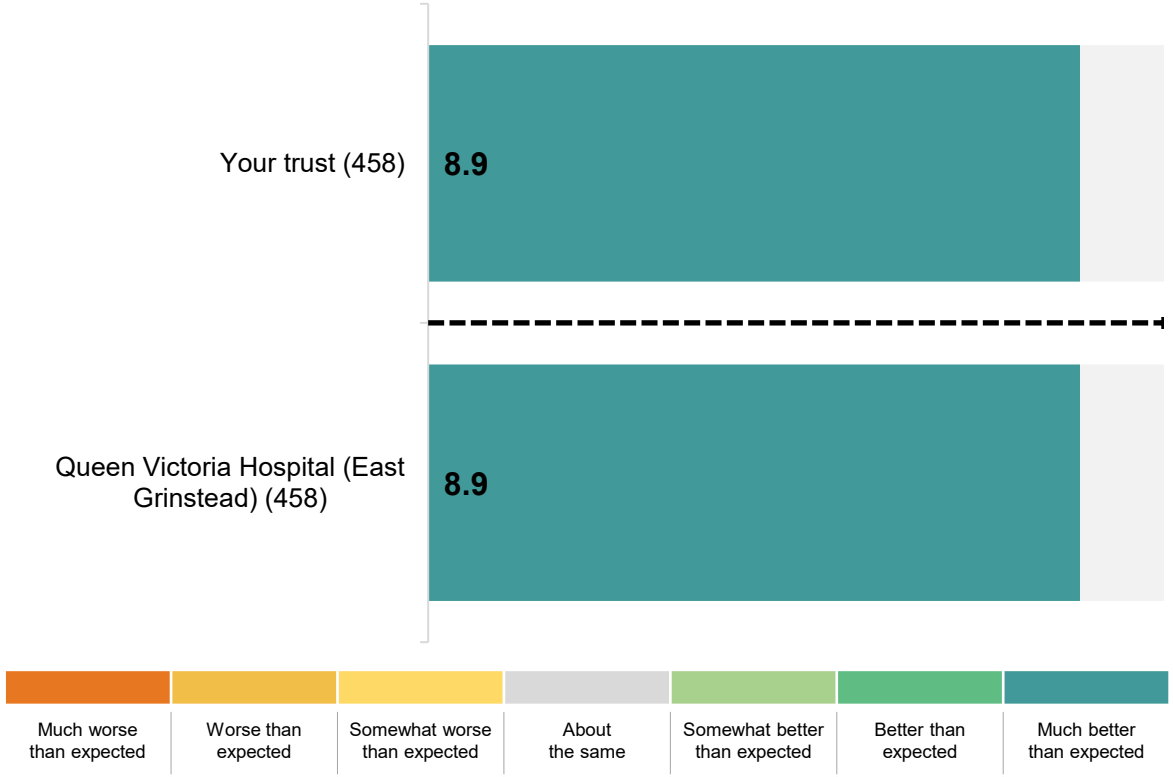
Please note: the number of respondents is shown in brackets next to the site name

Section 6. Your care and treatment

Q21. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



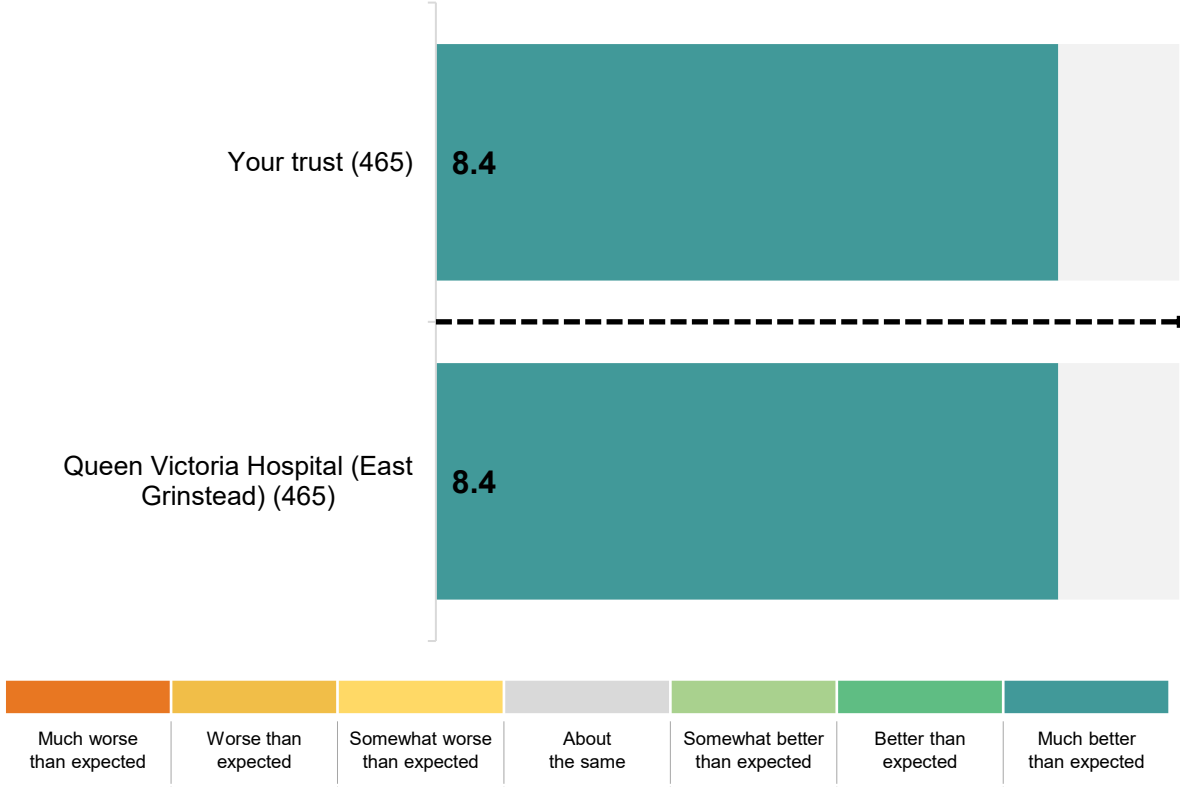
Please note: the number of respondents is shown in brackets next to the site name

Section 6. Your care and treatment

Q22. To what extent did staff looking after you involve you in decisions about your care and treatment?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



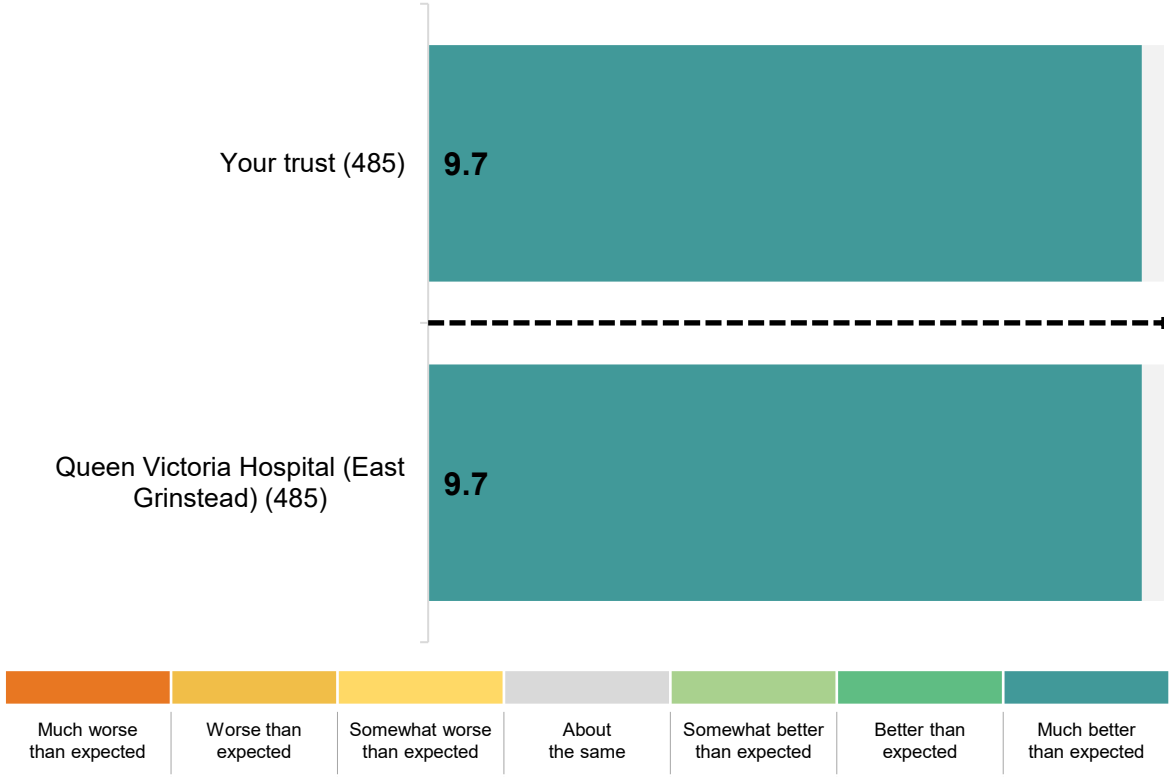
Please note: the number of respondents is shown in brackets next to the site name

Section 6. Your care and treatment

Q23. How much information about your condition or treatment was given to you?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



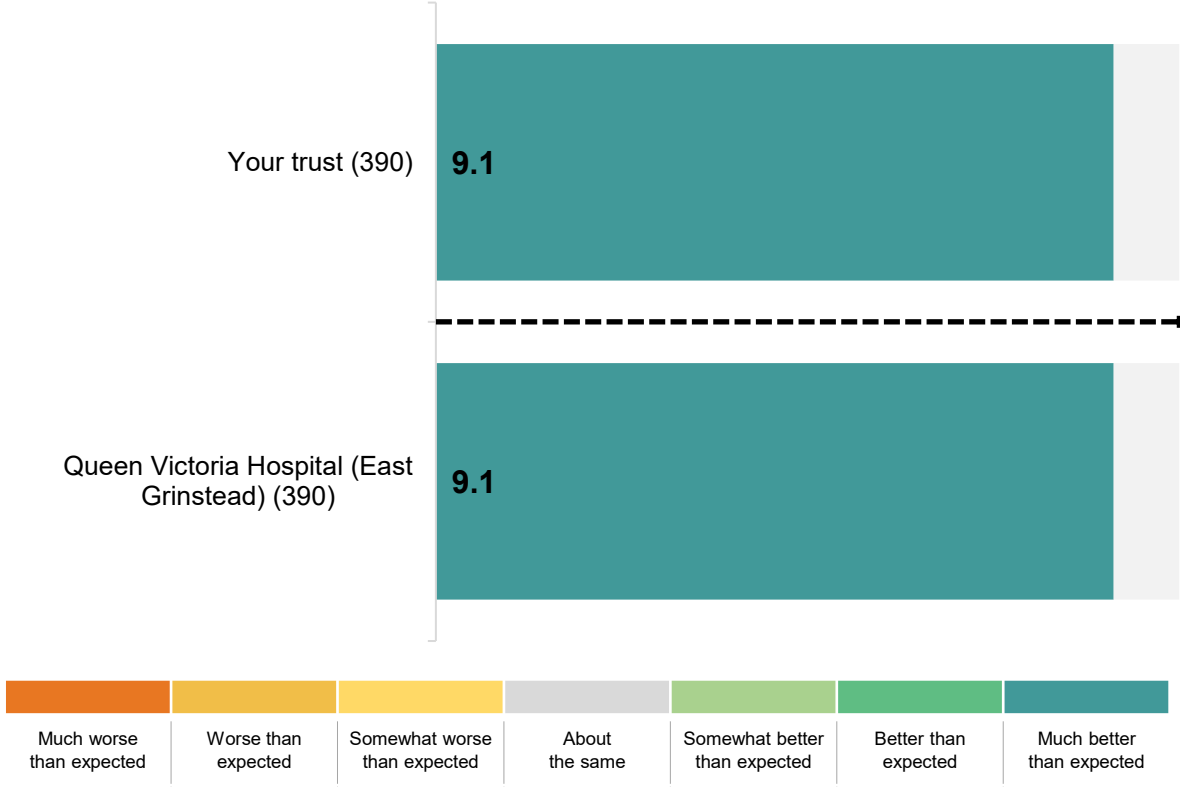
Please note: the number of respondents is shown in brackets next to the site name

Section 6. Your care and treatment

Q24. Did you feel able to talk to members of hospital staff about your worries and fears?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



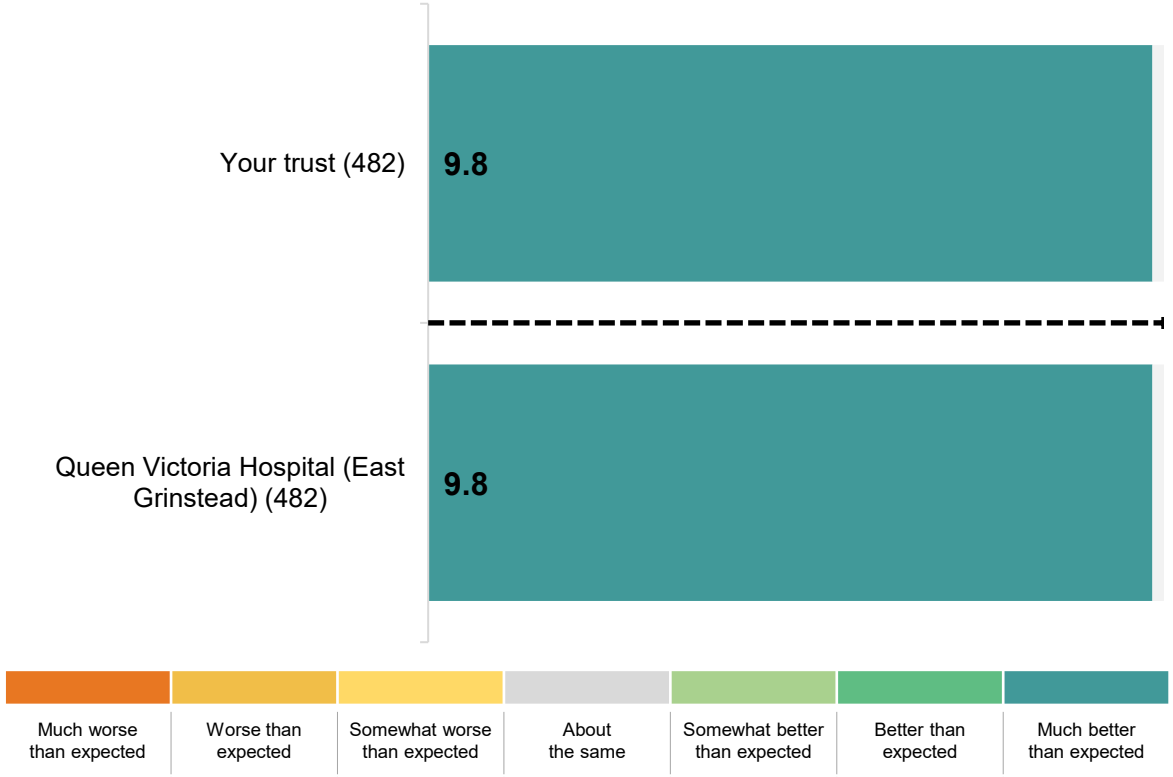
Please note: the number of respondents is shown in brackets next to the site name

Section 6. Your care and treatment

Q25. Were you given enough privacy when being examined or treated?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



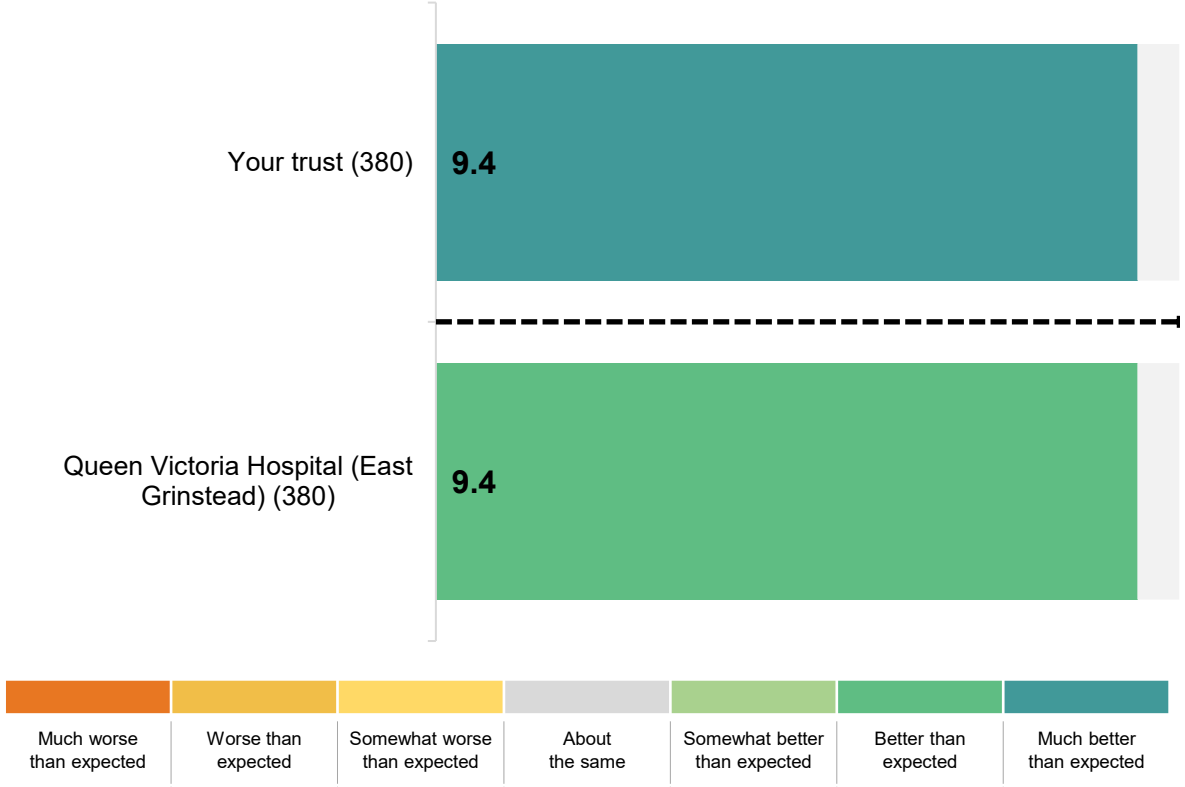
Please note: the number of respondents is shown in brackets next to the site name

Section 6. Your care and treatment

Q26. Do you think the hospital staff did everything they could to help control your pain?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



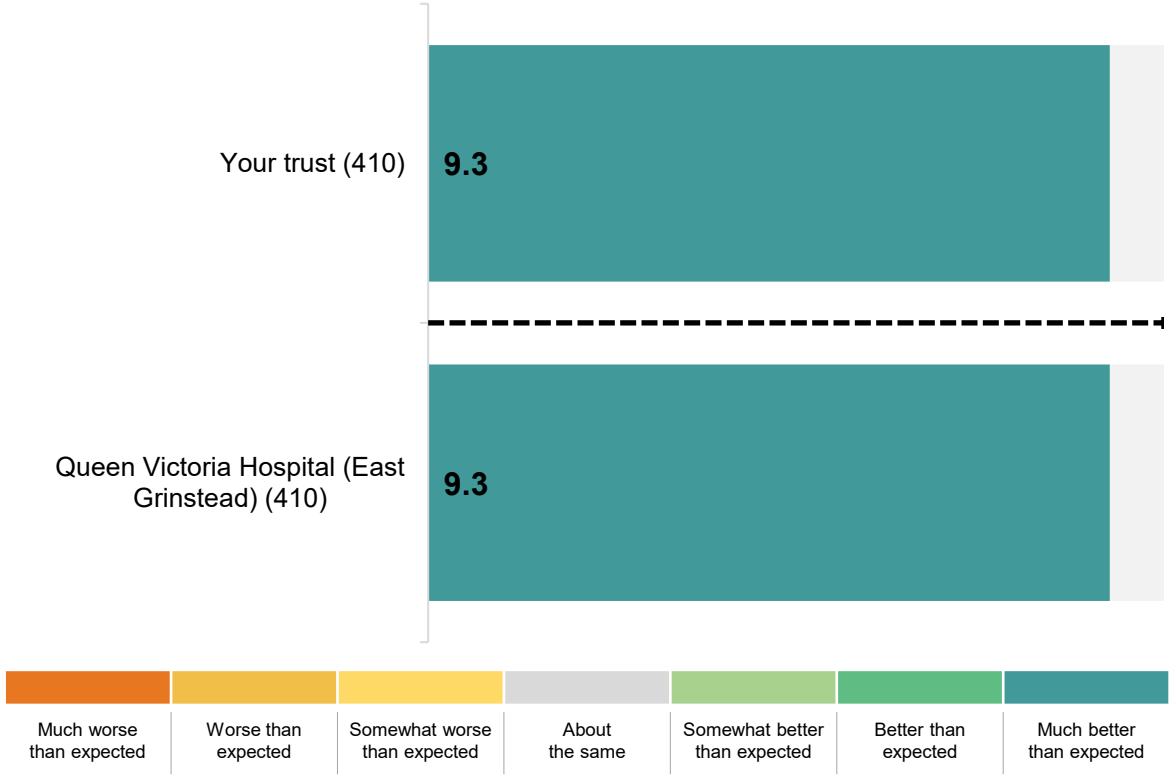
Please note: the number of respondents is shown in brackets next to the site name

Section 6. Your care and treatment

Q27. Were you able to get a member of staff to help you when you needed attention?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



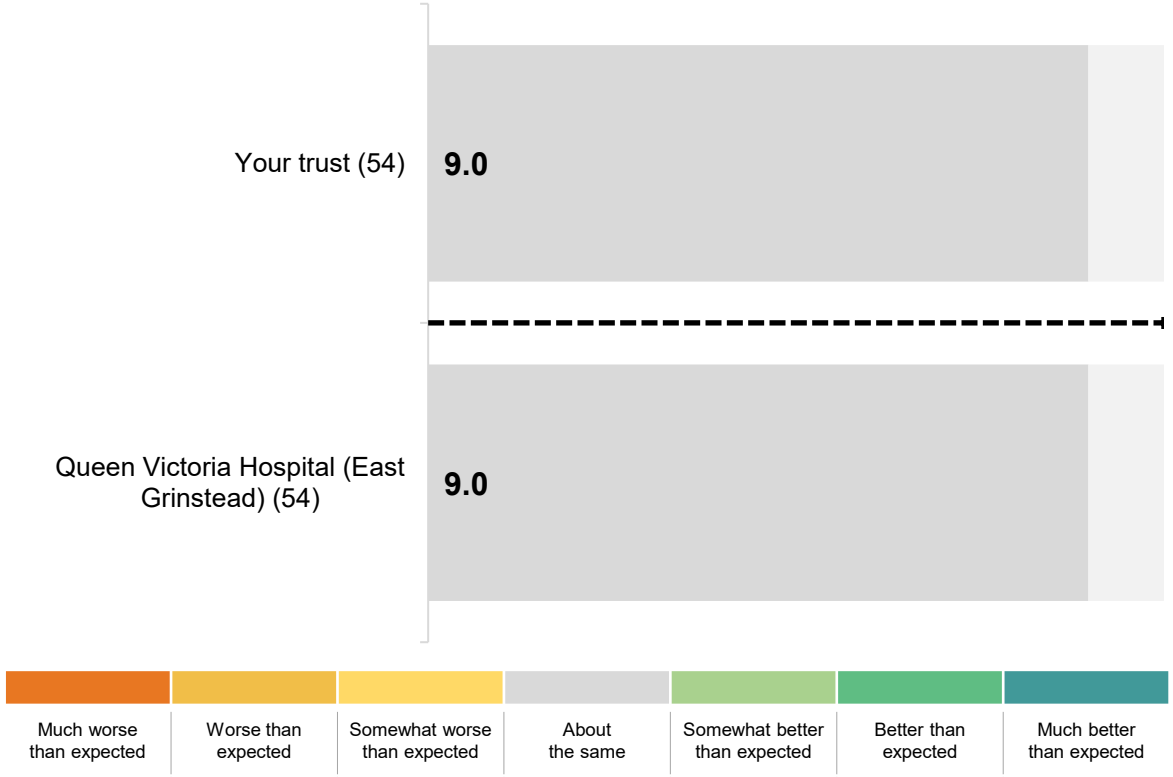
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Individual needs

Q28_1. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Language needs (e.g. translation, braille)

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



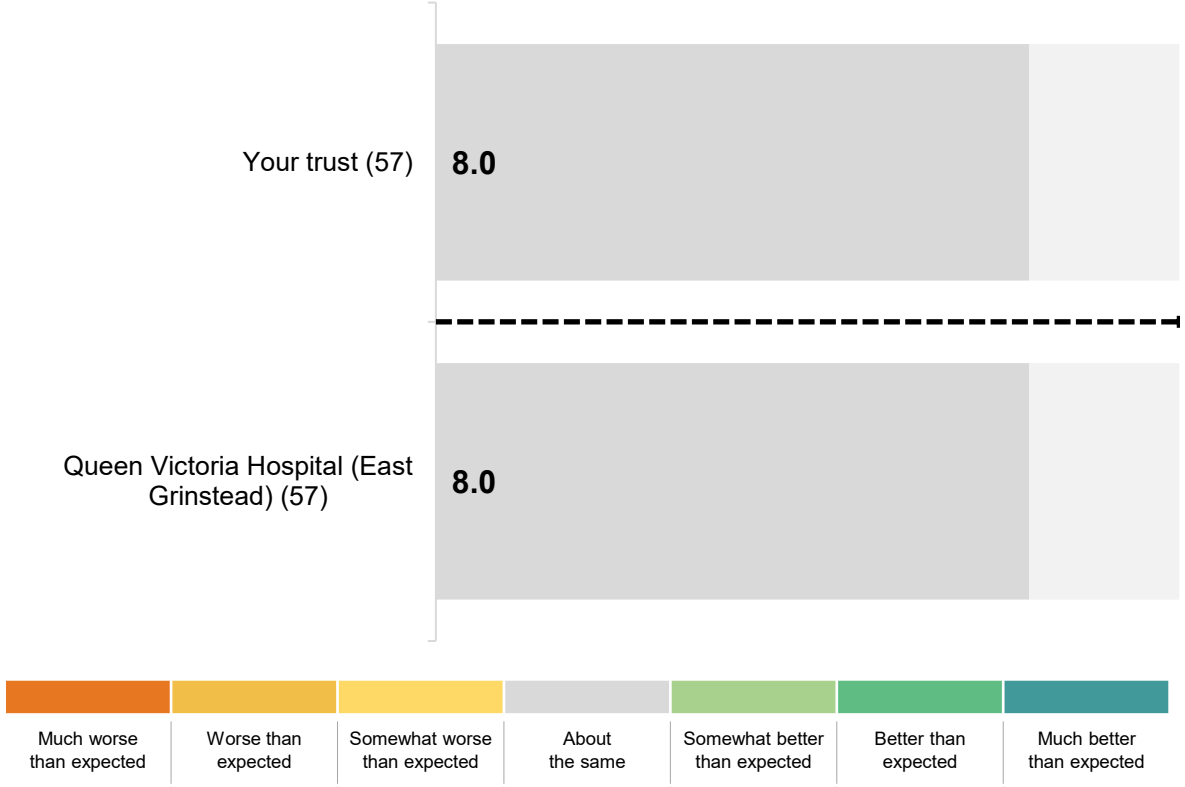
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Individual needs

Q28_2. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Cultural needs (e.g. same gender staff)

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



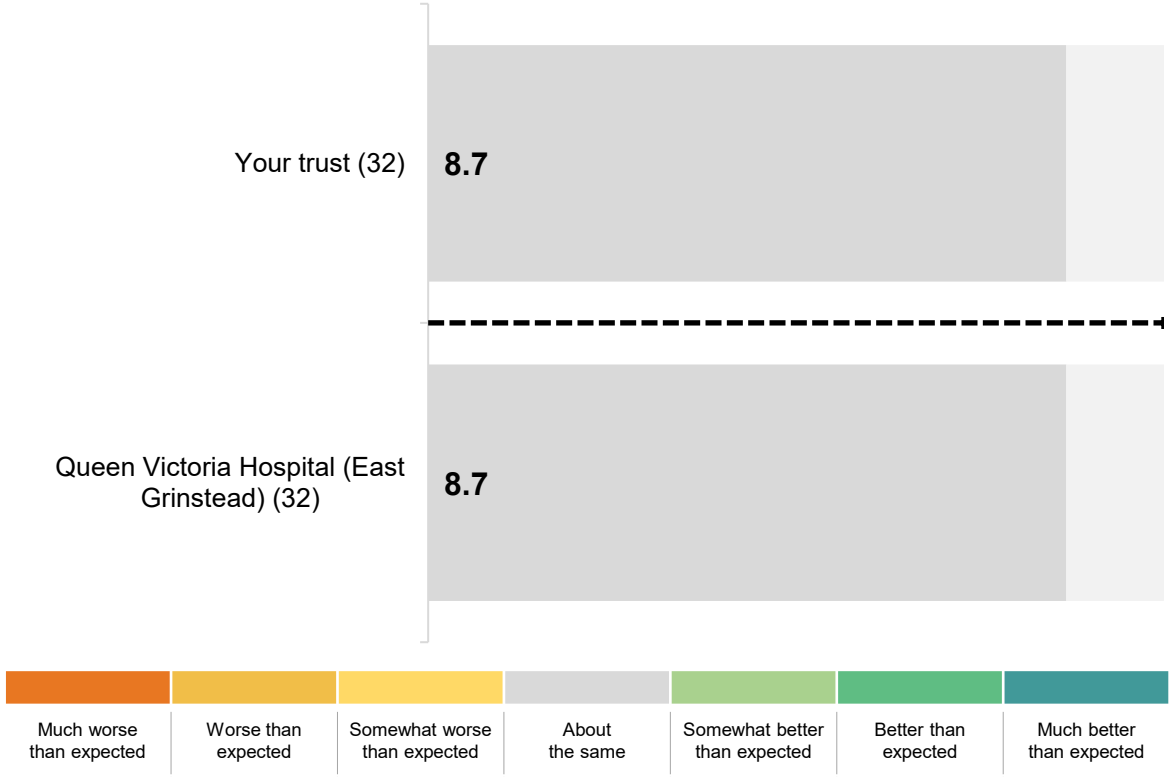
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Individual needs

Q28_3. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Religious needs (e.g. space to pray / meditate)

Results for your trust and sites

A mean score has been produced to enable trusts to monitor their trust and sites performance internally.



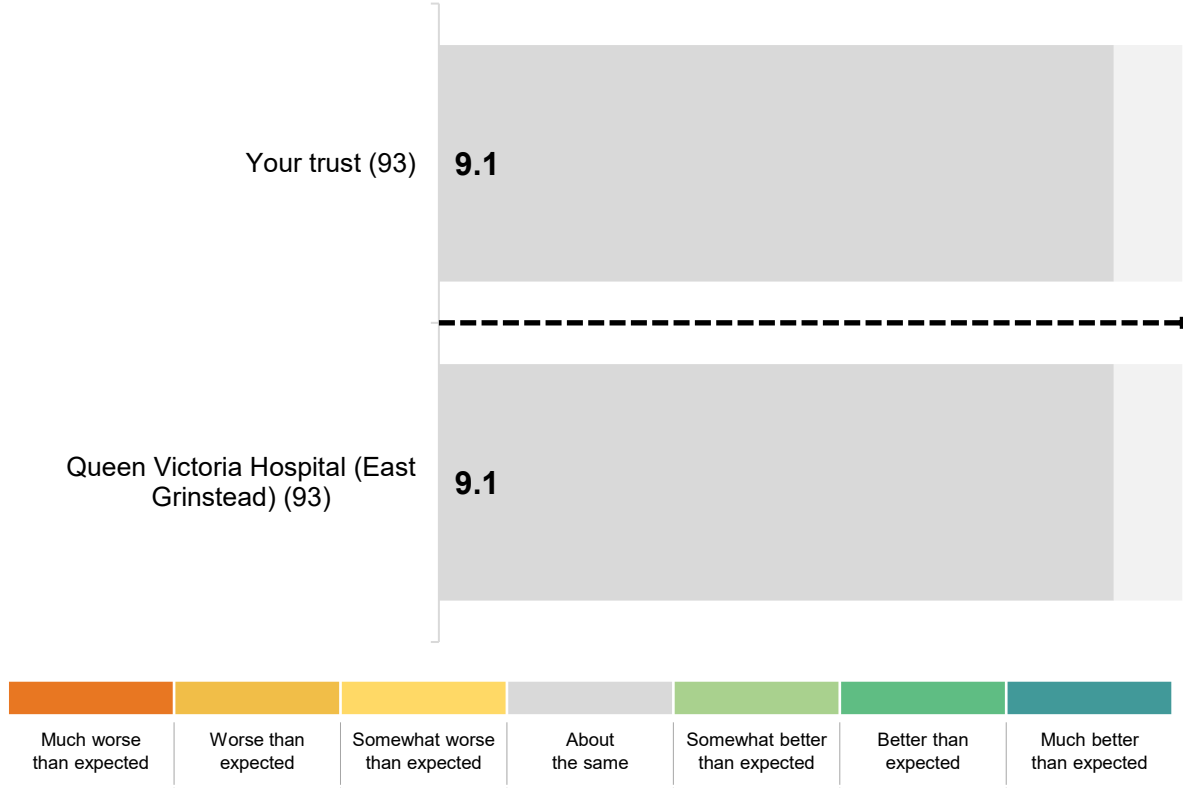
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Individual needs

Q28_4. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Accessibility needs (e.g. mobility needs, room adaptations)

Results for your trust and sites

A mean score has been produced to enable trusts to monitor their trust and sites performance internally.



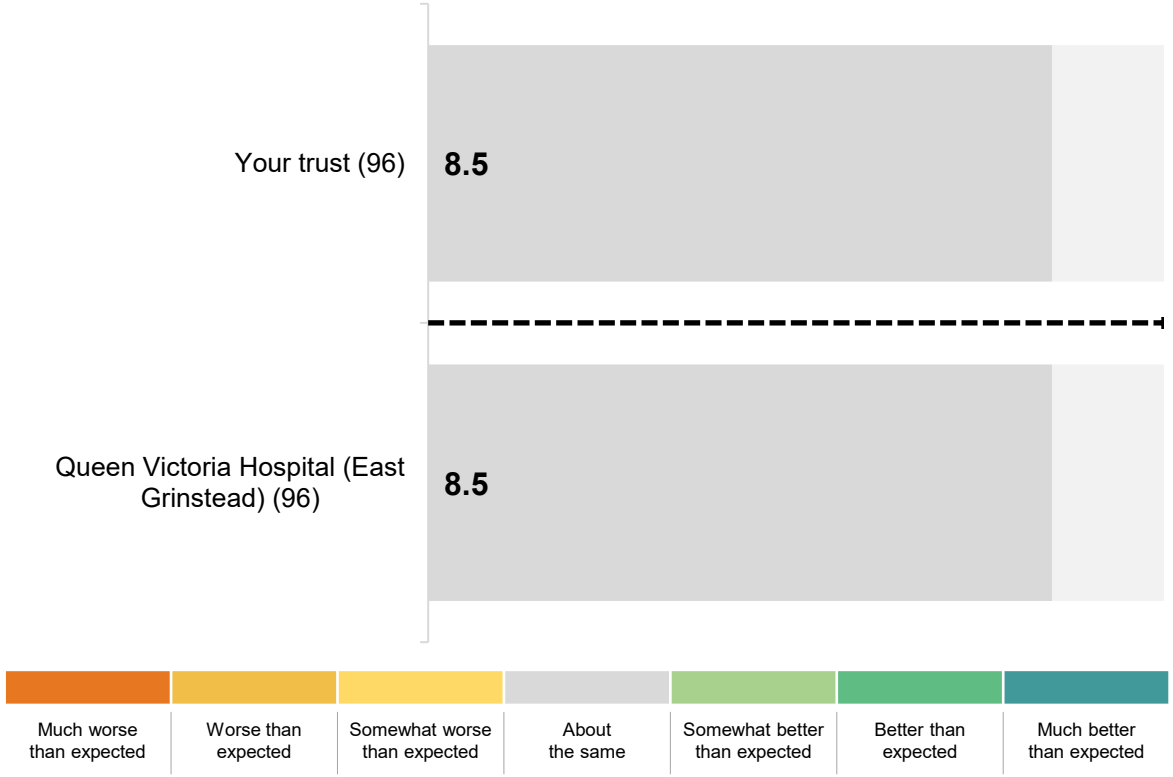
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Individual needs

Q28_5. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Dietary needs (e.g. medical, allergy, vegan)

Results for your trust and sites

A mean score has been produced to enable trusts to monitor their trust and sites performance internally.



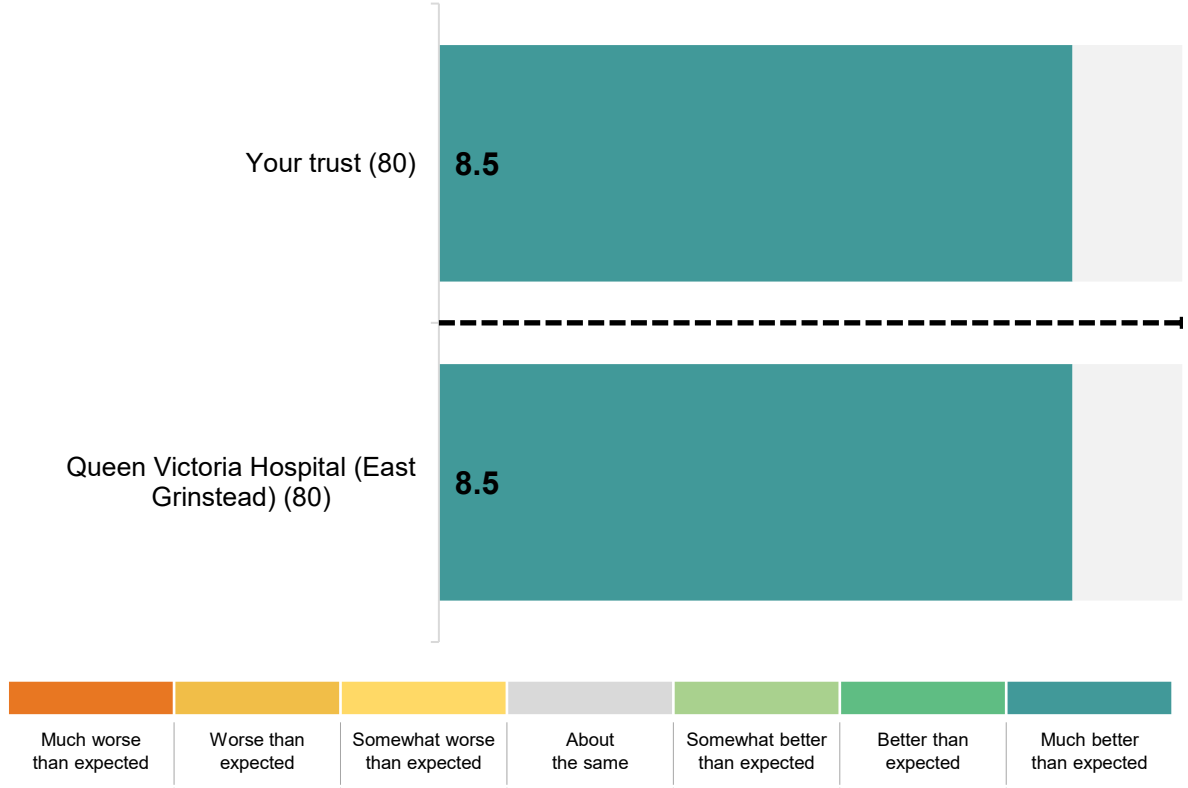
Please note: the number of respondents is shown in brackets next to the site name

Section 7. Individual needs

Q28_6. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Mental health needs (e.g. a quiet space, emotional support)

Results for your trust and sites

A mean score has been produced to enable trusts to monitor their trust and sites performance internally.



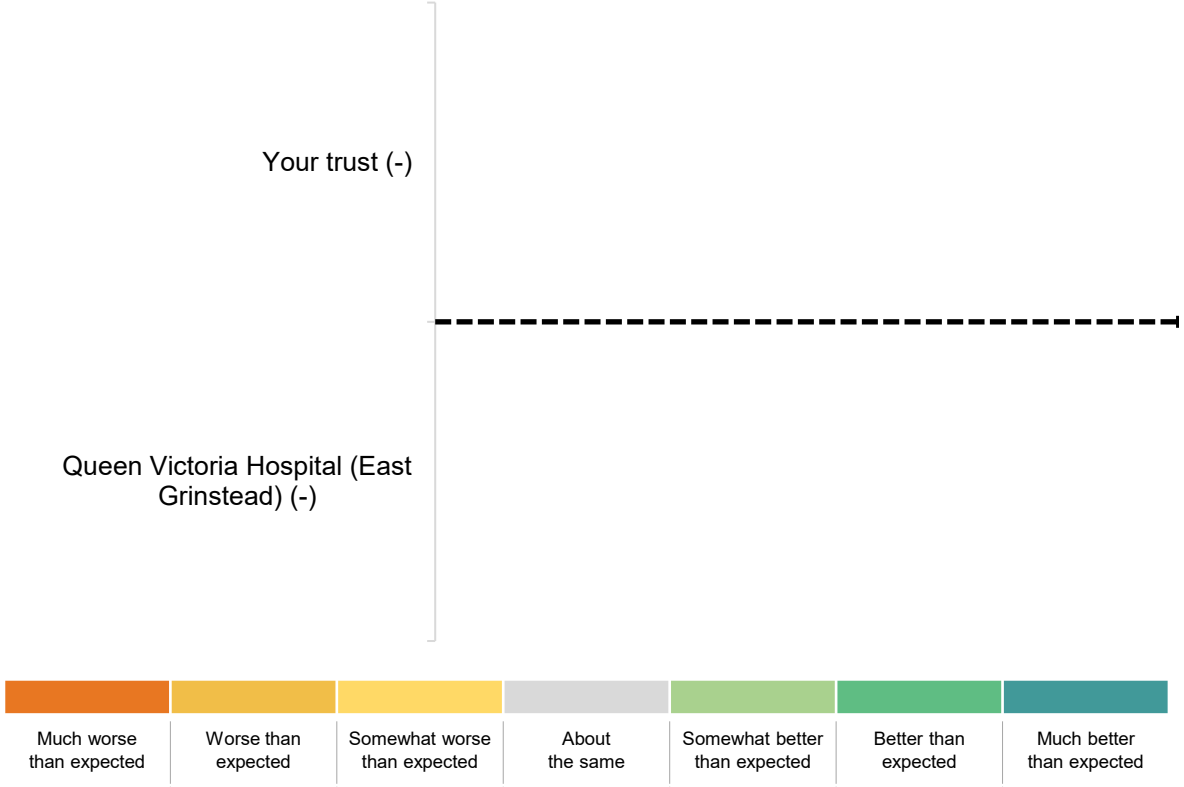
Please note: the number of respondents is shown in brackets next to the site name

Section 8. Virtual wards

Q30. Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



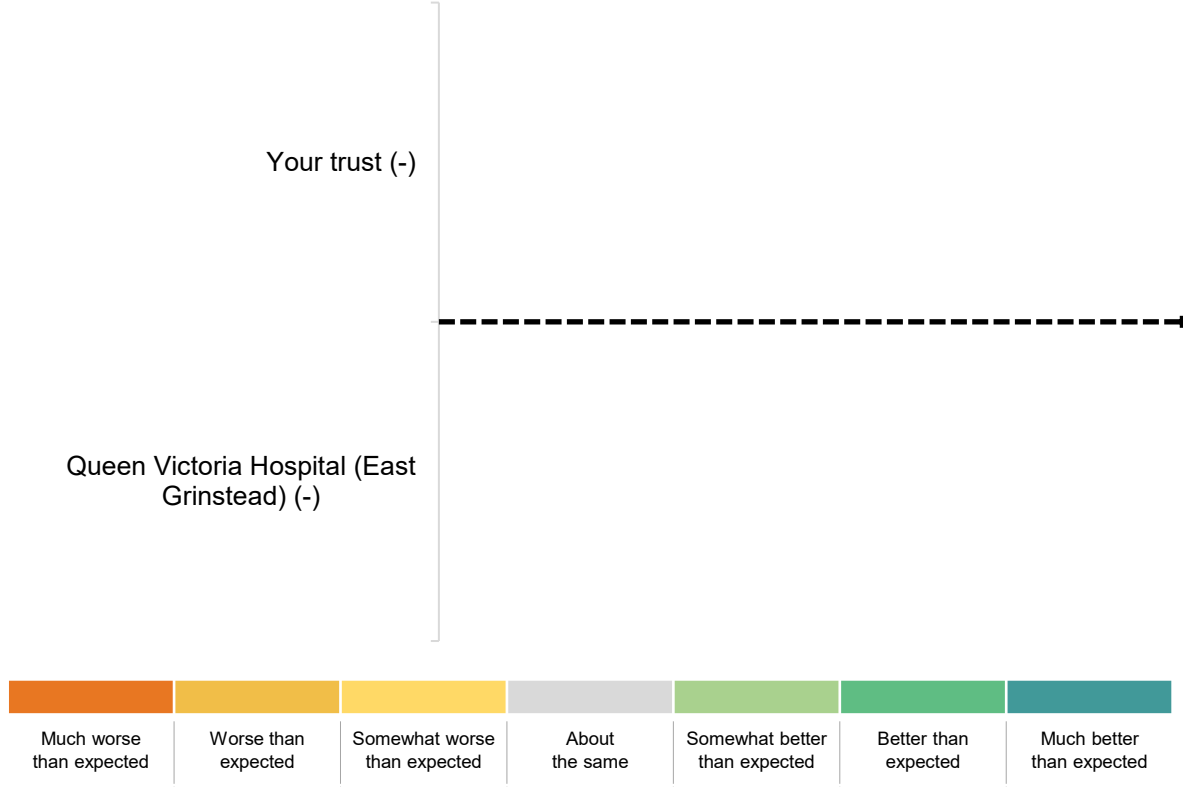
Please note: the number of respondents is shown in brackets next to the site name

Section 8. Virtual wards

Q31. Were you given enough information about the care and treatment you would receive while on a virtual ward?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



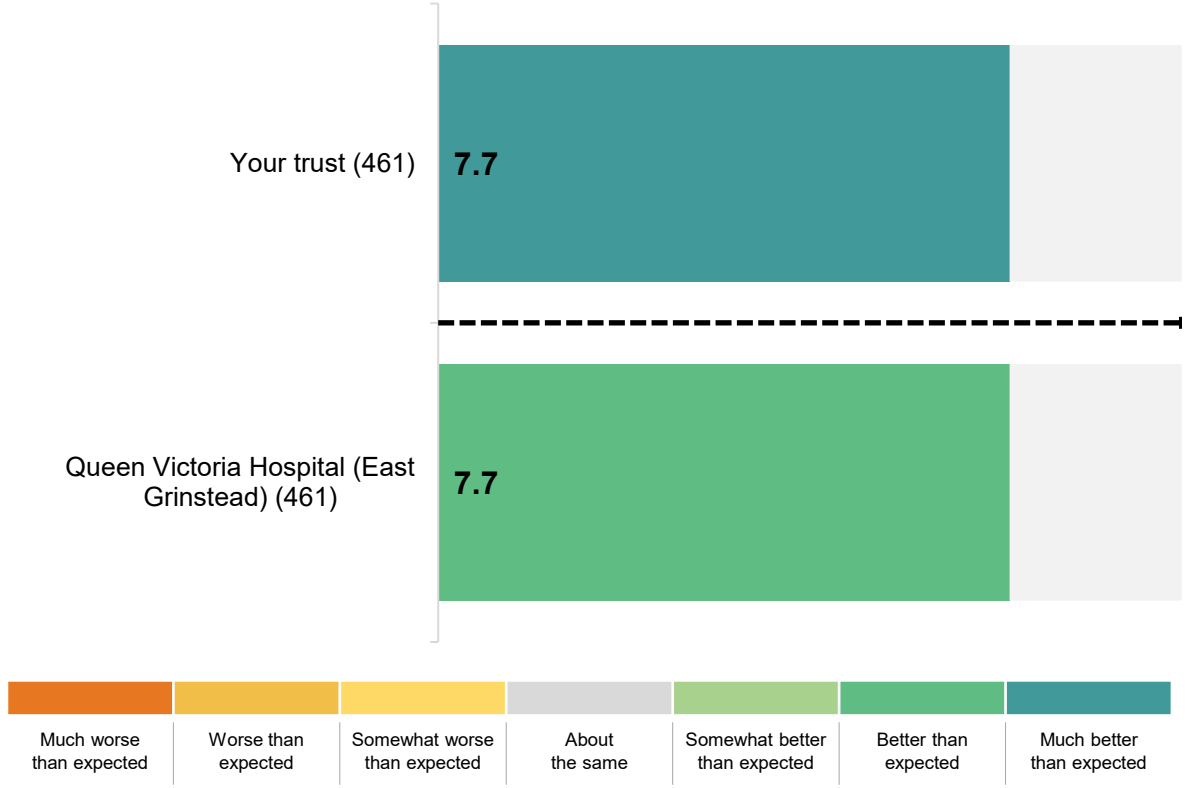
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q32. To what extent did staff involve you in decisions about leaving the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



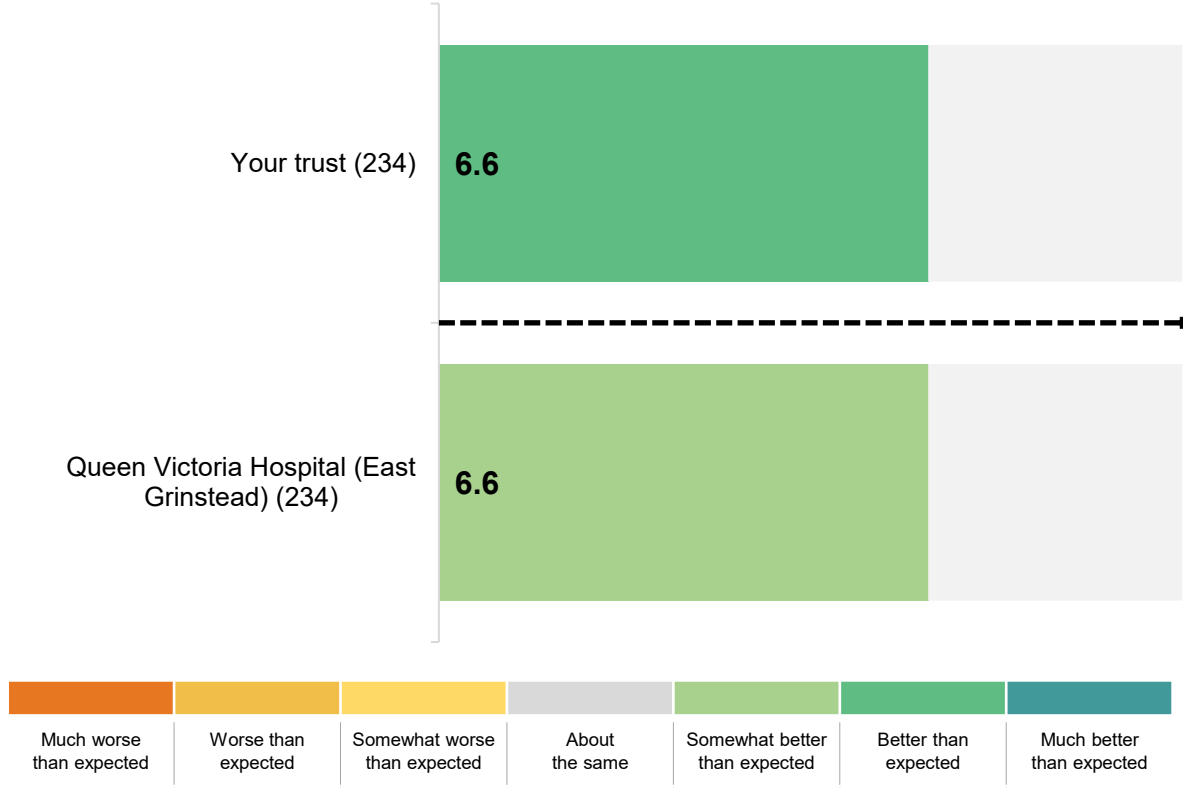
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q33. To what extent did hospital staff involve your family or carers in decisions about you leaving the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



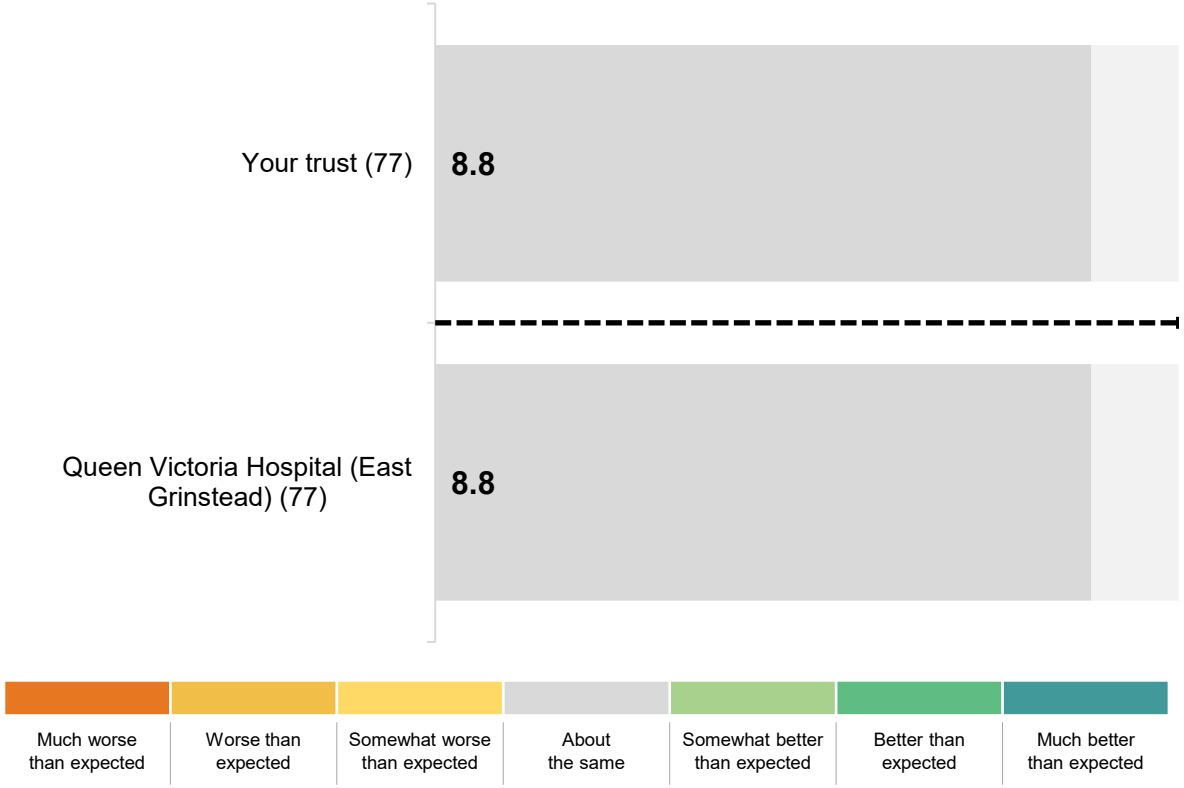
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q34. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



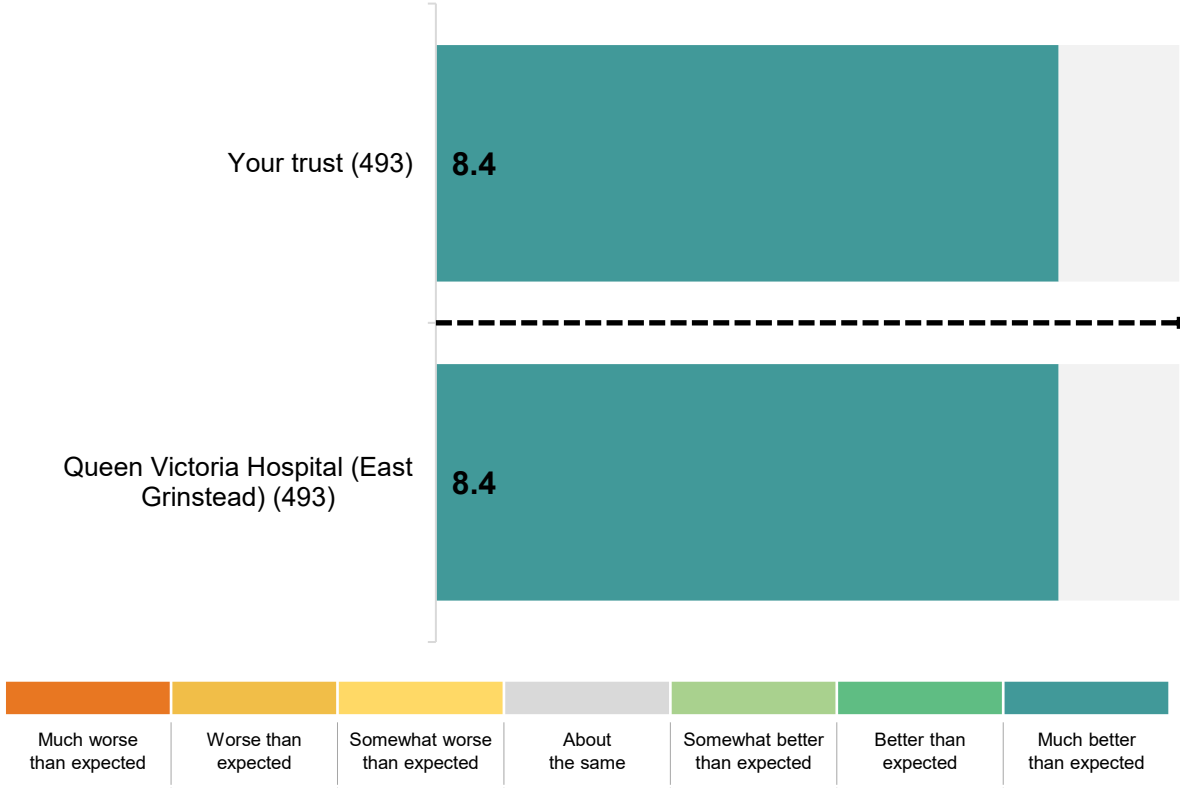
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q35. Were you given enough notice about when you were going to leave hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



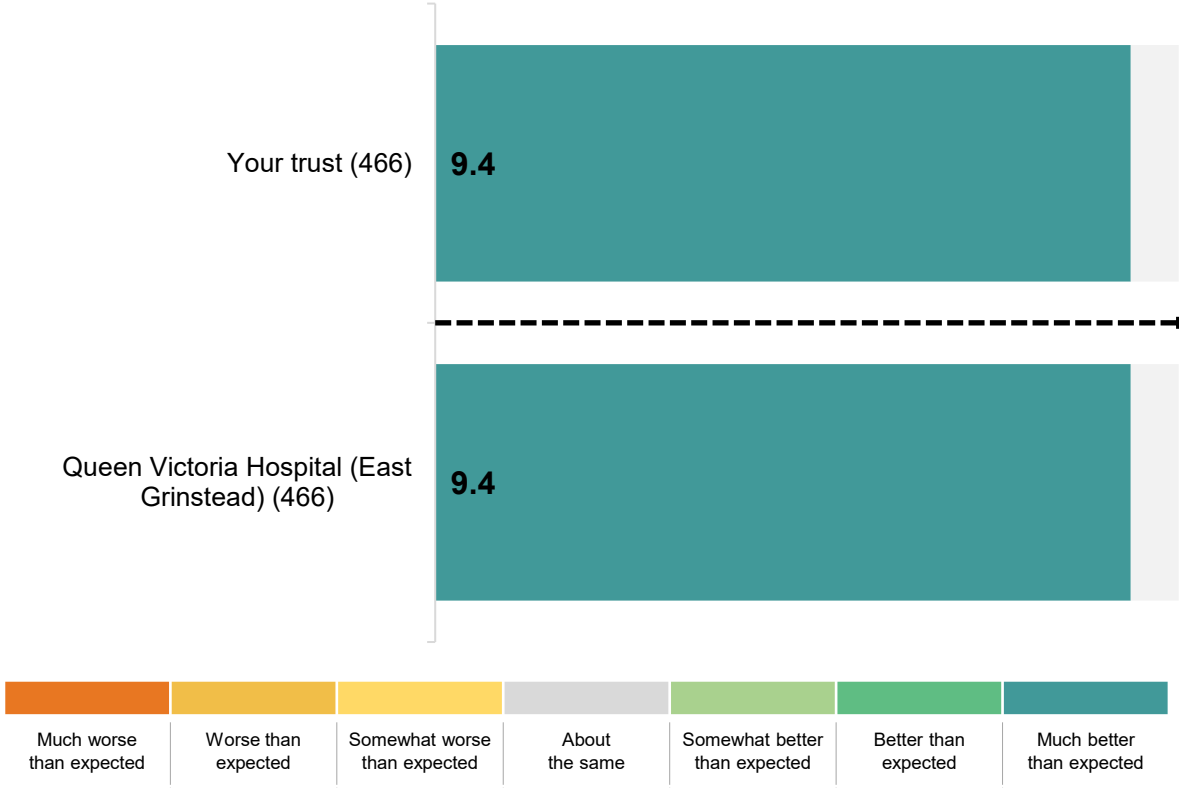
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q36. Before you left the hospital, were you given any information about what you should or should not do after leaving the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



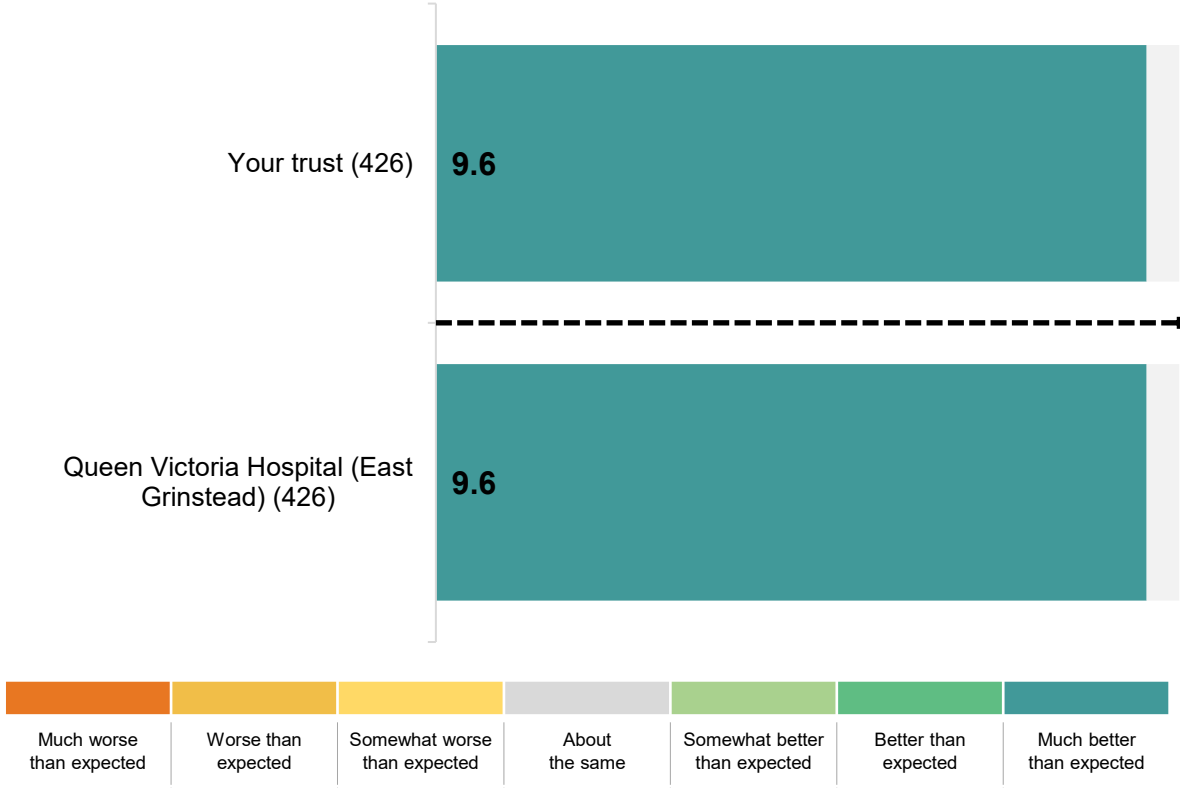
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q37. To what extent did you understand the information you were given about what you should or should not do after leaving the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



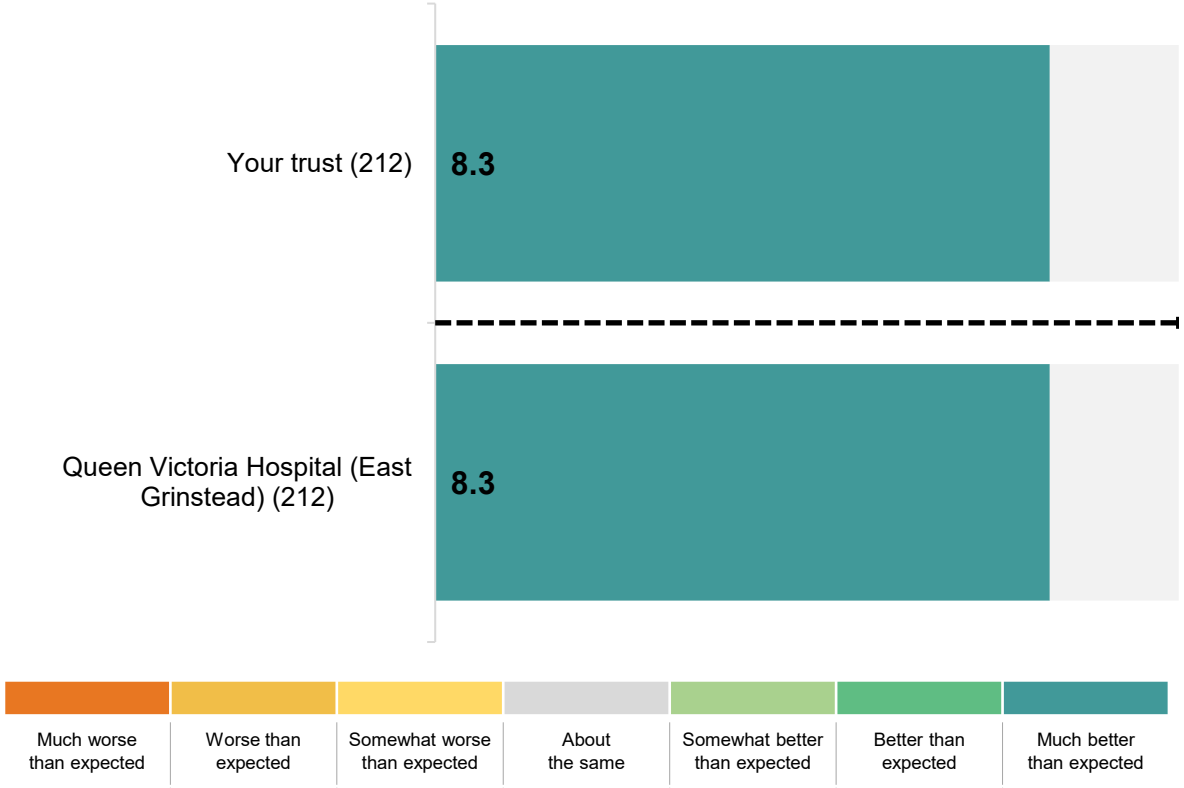
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q38. Before you left the hospital, were your family or carers given the information they needed to care for you at home?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



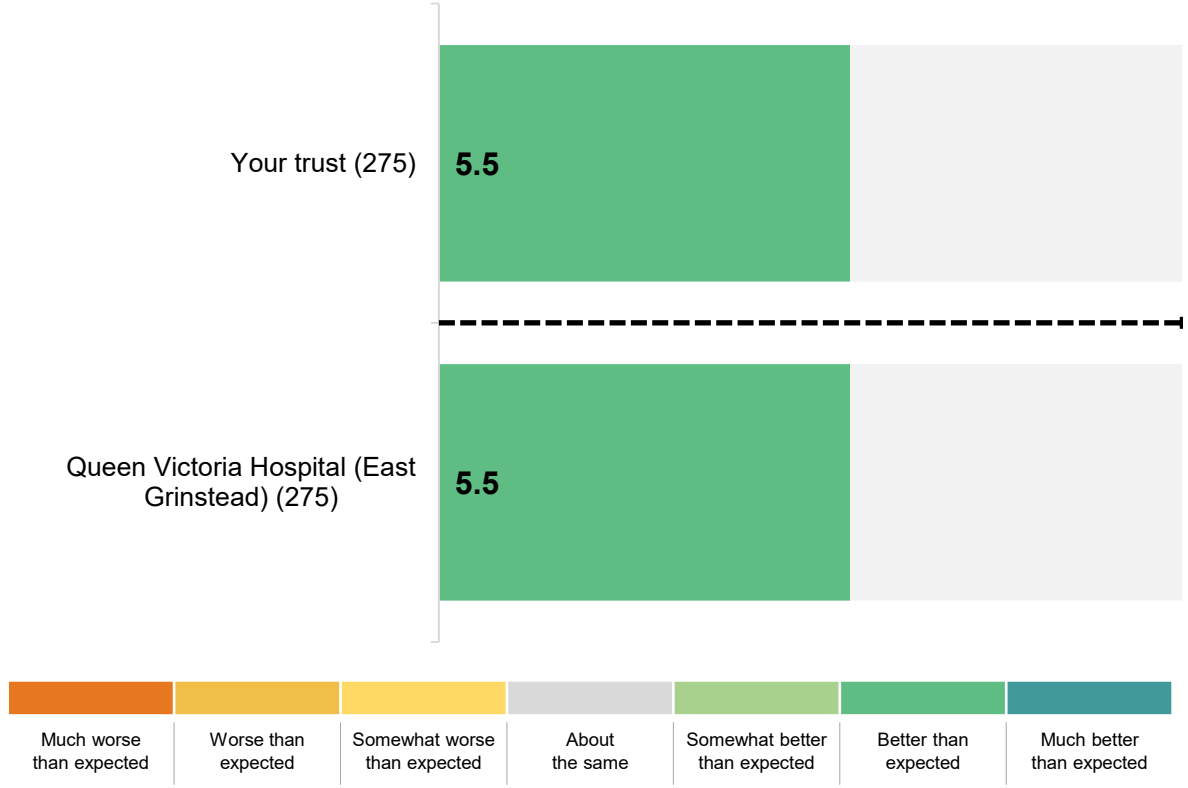
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q39. Thinking about any medicine you were to take at home, were you given any of the following?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



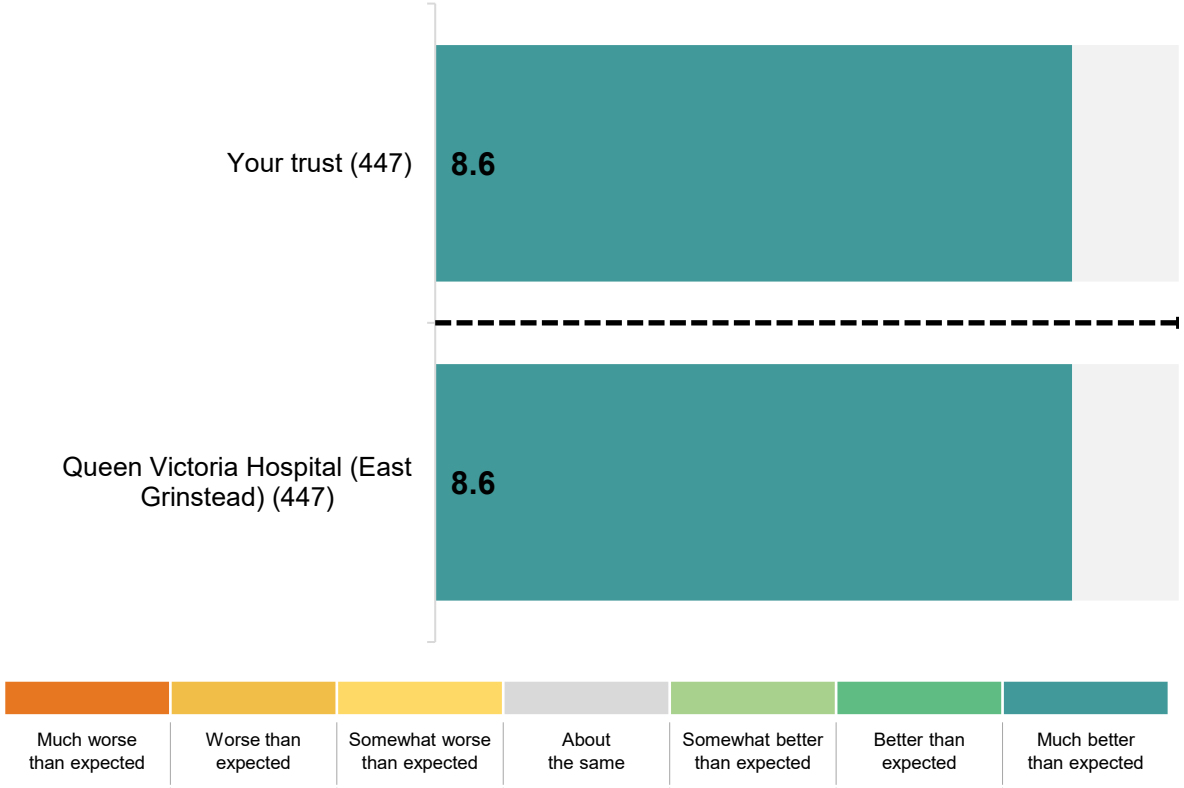
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q40. Before you left the hospital, did you know what would happen next with your care?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



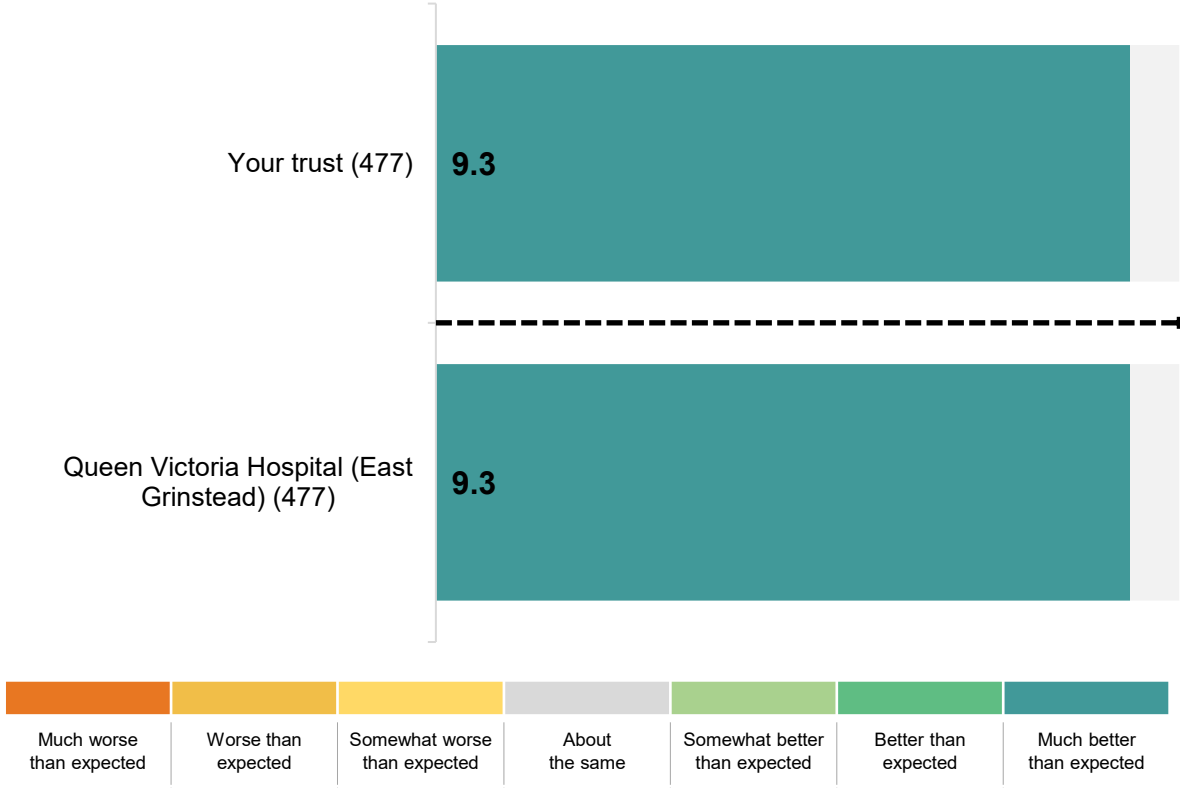
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



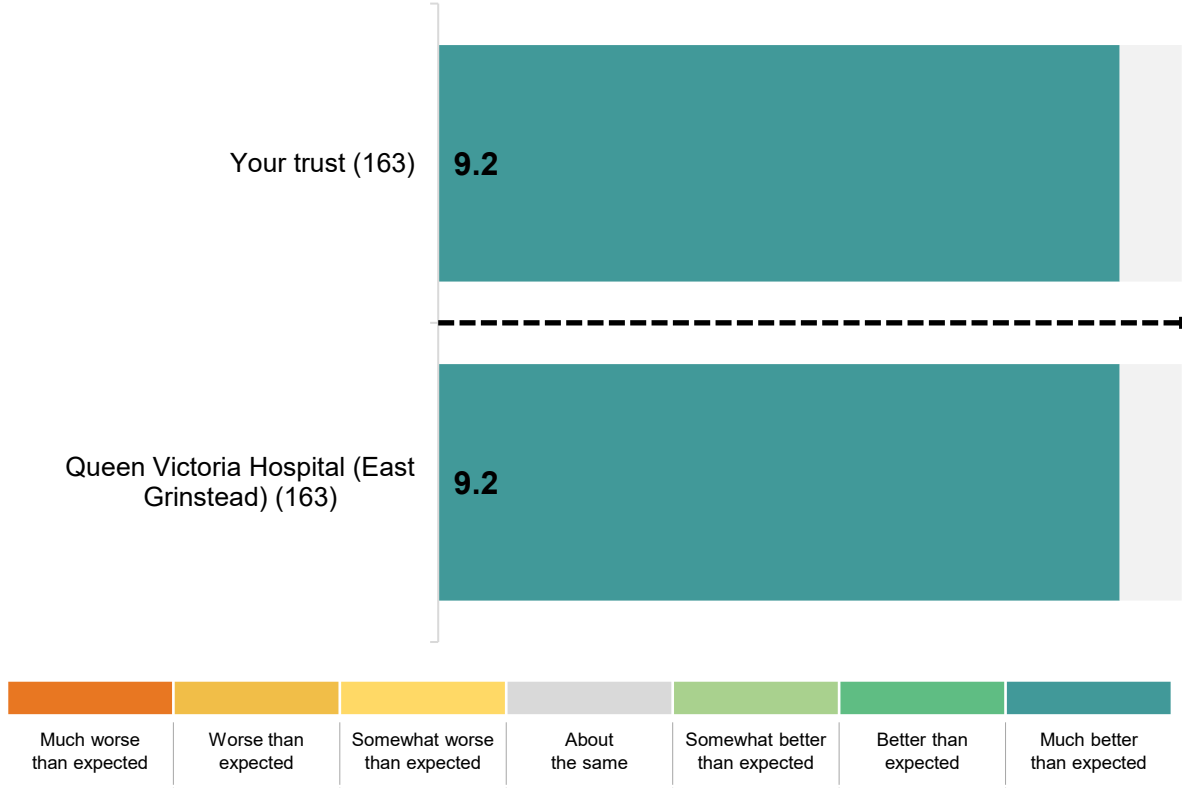
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



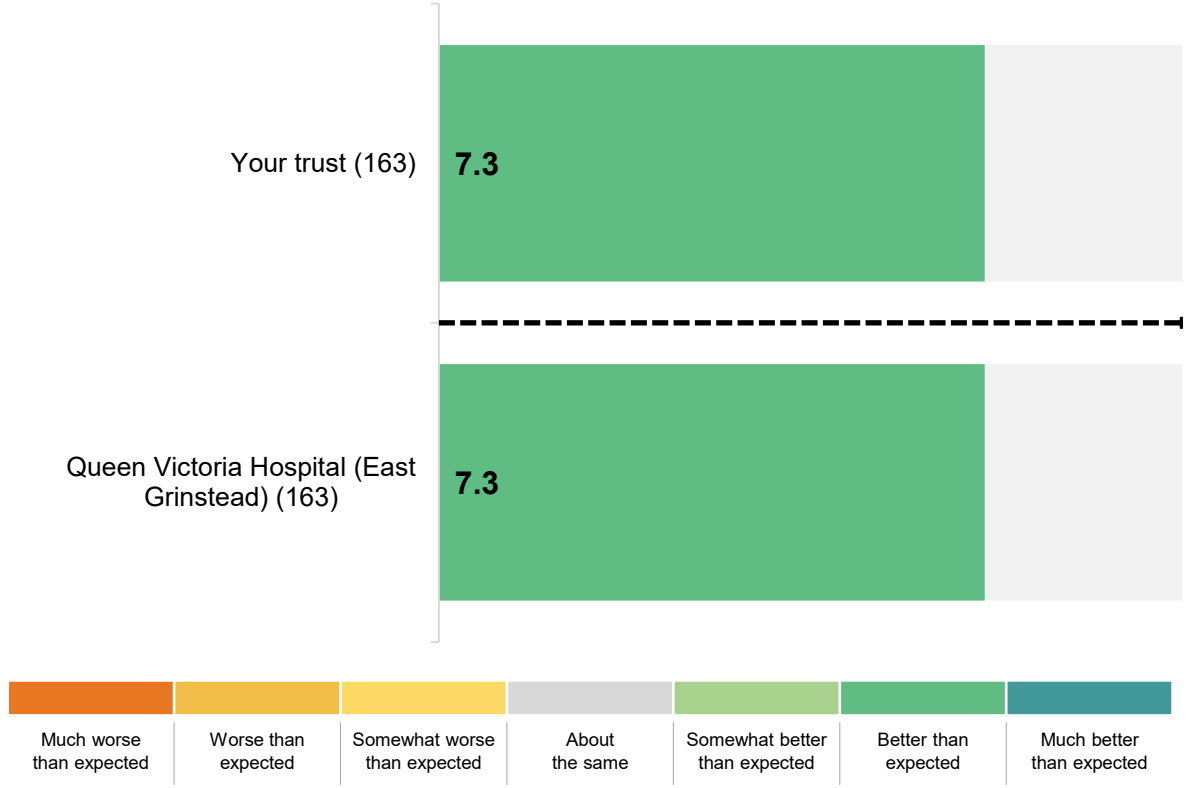
Please note: the number of respondents is shown in brackets next to the site name

Section 9. Leaving hospital

Q43. After leaving the hospital, did you get enough support from health or social care services to help you recover or manage your condition?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



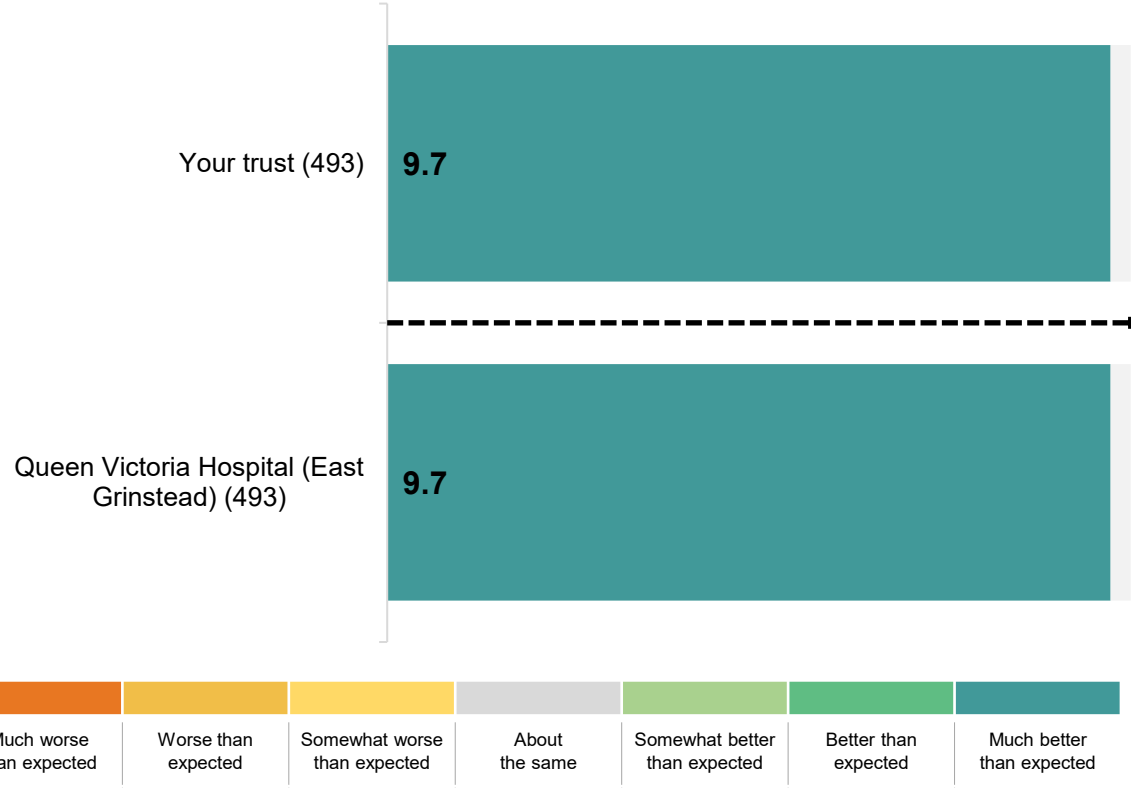
Please note: the number of respondents is shown in brackets next to the site name

Section 10. Kindness and compassion

Q44. Overall, did you feel you were treated with kindness and compassion while you were in the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



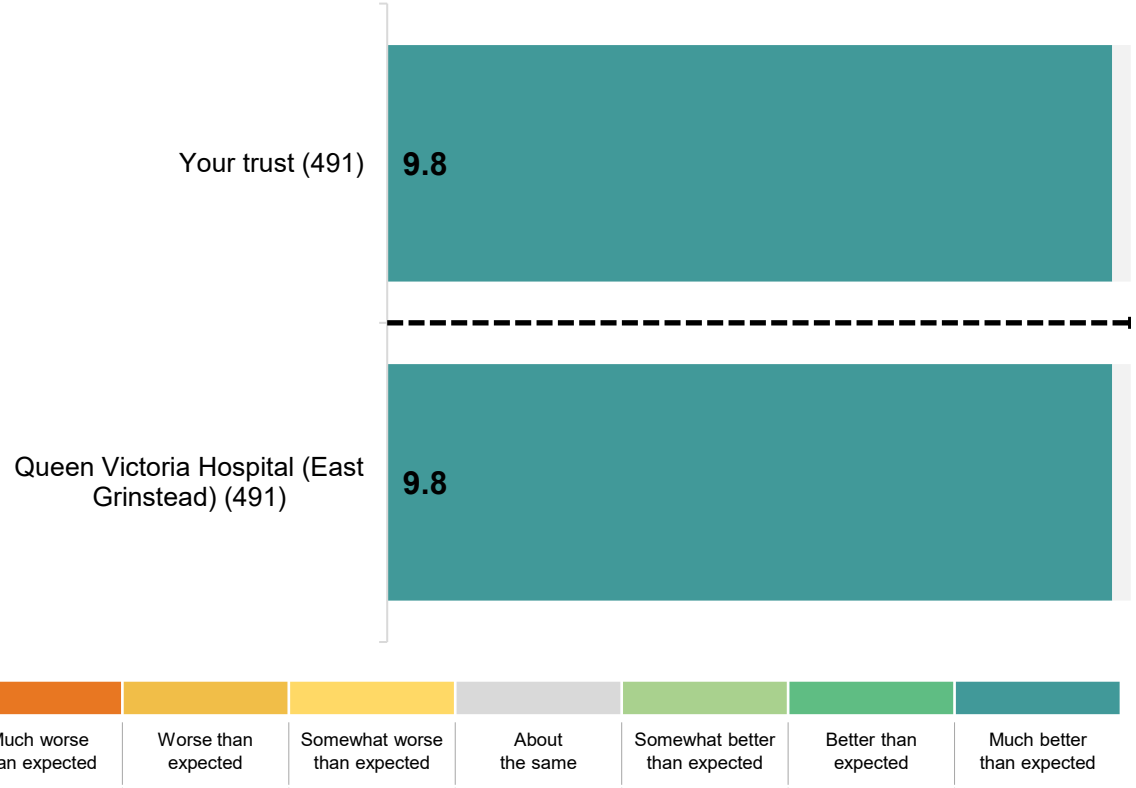
Please note: the number of respondents is shown in brackets next to the site name

Section 11. Respect and dignity

Q45. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



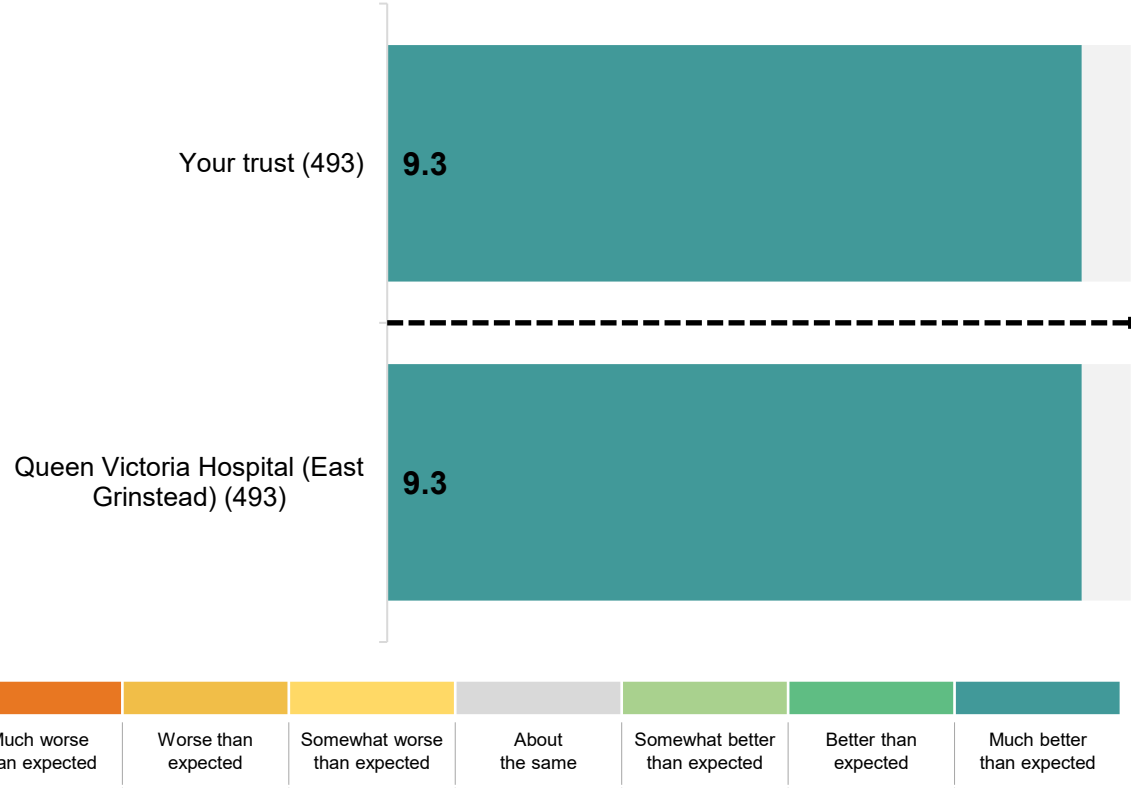
Please note: the number of respondents is shown in brackets next to the site name

Section 12. Overall experience

Q46. Overall, how was your experience while you were in the hospital?

Results for your trust and sites

This benchmarking compares the question score for your trust against all other trusts, and the score for your trust's sites against all other sites across all trusts.



Please note: the number of respondents is shown in brackets next to the site name

Change over time

This section includes:

- guidance on how to interpret the data for change over time
- your mean trust score for each evaluative question in the survey
- where comparable data is available, statistical significance testing using a two sample t-test has been carried out against the 2024 and 2023 survey results for each relevant question. Where a change in results is shown as ‘significant’, this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust.
- the following scored questions were new or changed for 2025 and therefore are not included in this section: Q28_6, Q38.
- the following questions are non-comparable and therefore are not included in this section: Q28_1 – Q28_5, Q33.

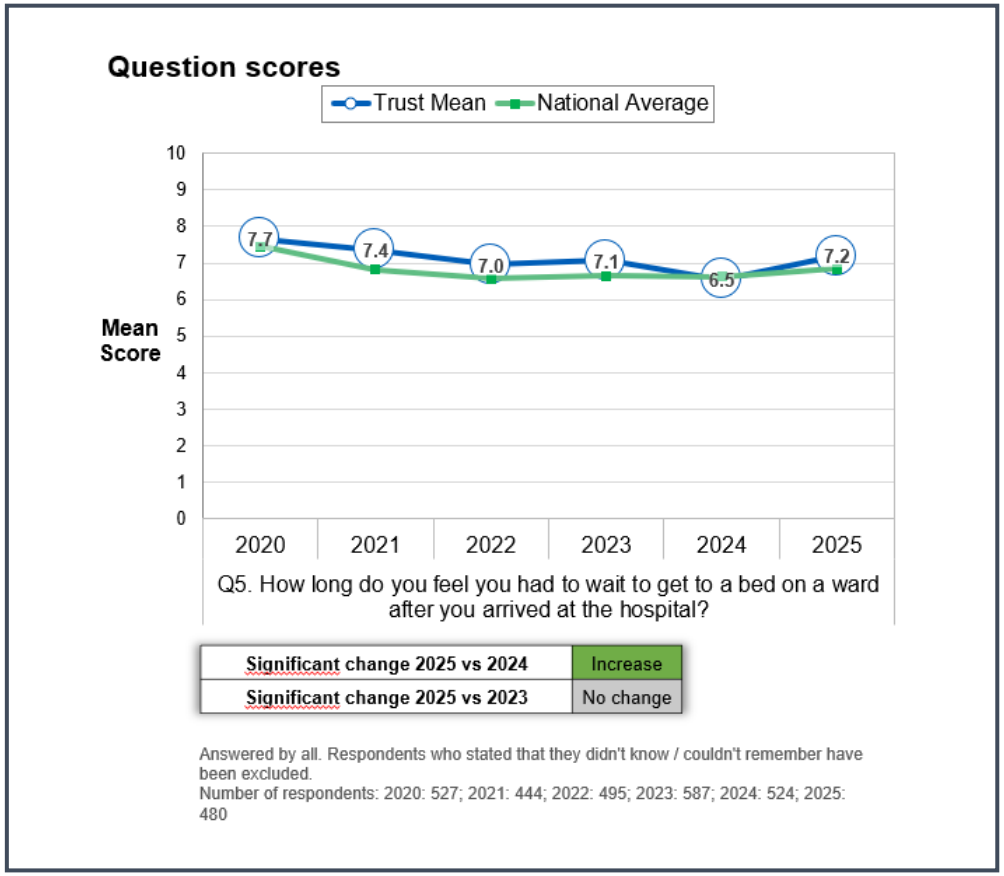
Please note: If data is missing for a survey year, this is due to a low number of responses, or because the trust data was not included in the survey that year, due to sampling errors or ineligibility.

How to interpret change over time in this report

The charts in the 'change over time' section show how your trust scored in each Inpatient survey iteration. Where available, trend data from 2020 to 2025 is shown. If a question only has one data point, this question is not shown. Questions that are not historically comparable, are also not shown.

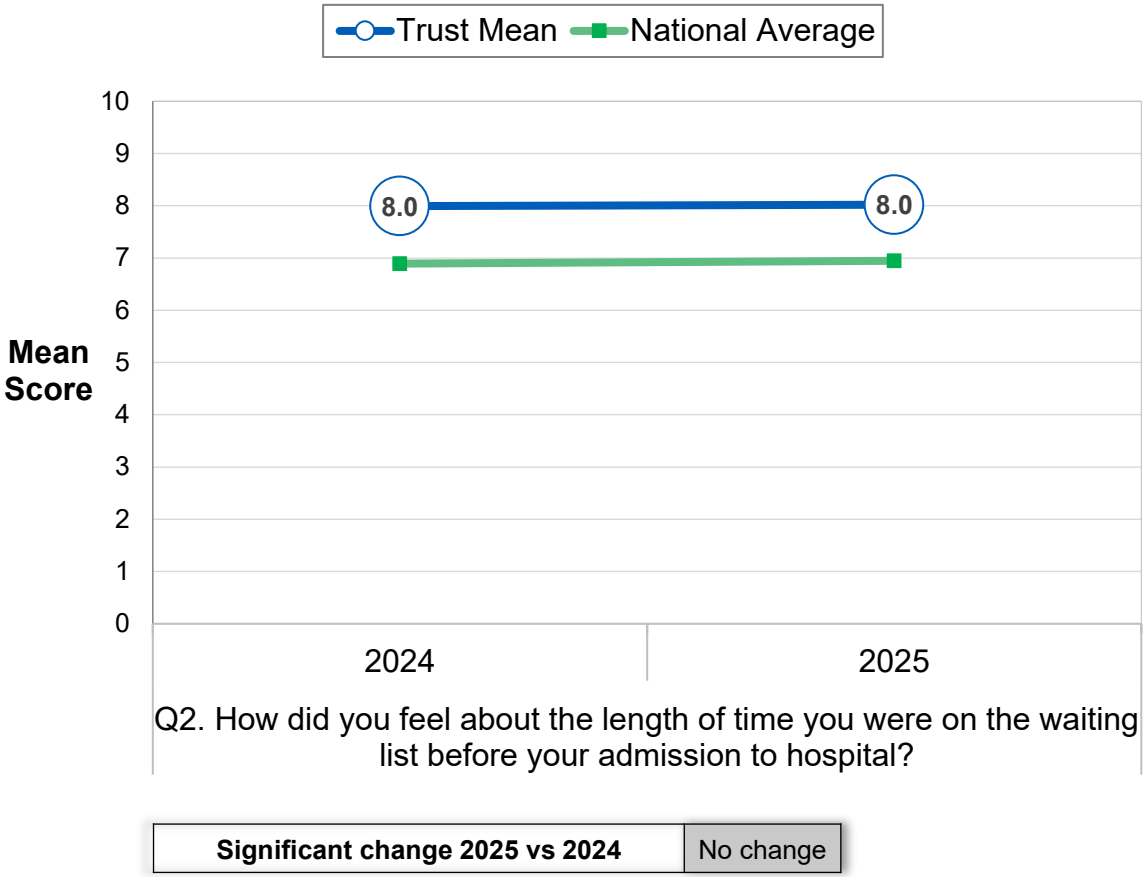
Each question is displayed in a line chart. These charts show your trust mean score for each survey year (blue line). The national average is also shown across survey years, this is the average score for that question across all NHS trusts with Adult Inpatient services in England (green line). This enables you to see how your trust compares to the national average. If there is data missing for a survey year, this may be due to either a low number of responses, because the trust was not included in the survey that year, sampling errors or ineligibility.

Statistically significant changes are also displayed in tables underneath the charts, showing significant differences between this year (2025) and the previous years (2024 and 2023). Two sample t-tests with a 95% significance level were used to compare data between 2025 and 2024, and 2024 and 2022. A statistically significant difference means it is unlikely that we would have obtained this result if there was no real difference.



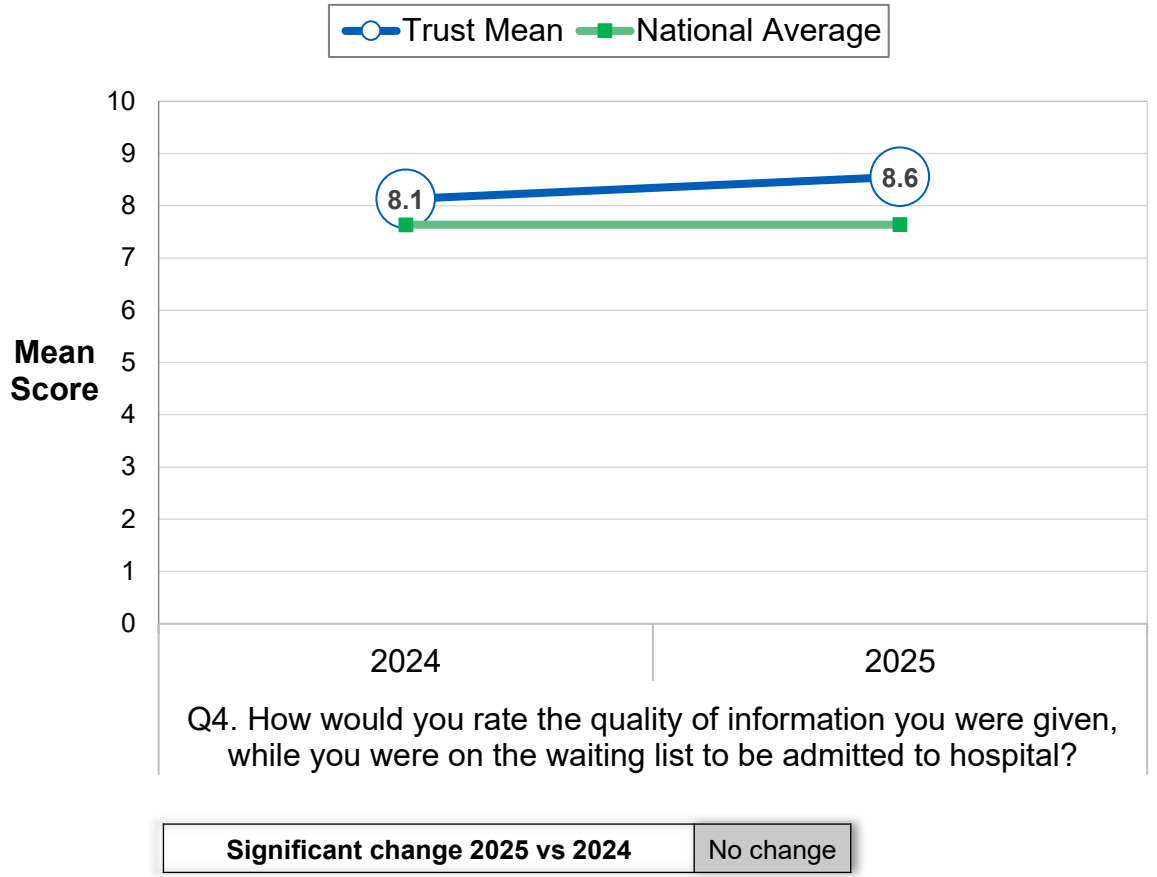
Section 1. Admission to hospital

Question scores



Significant change 2025 vs 2024	No change

Answered by those whose most recent hospital admission was waiting list or planned in advance.
Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2024: 378; 2025: 322

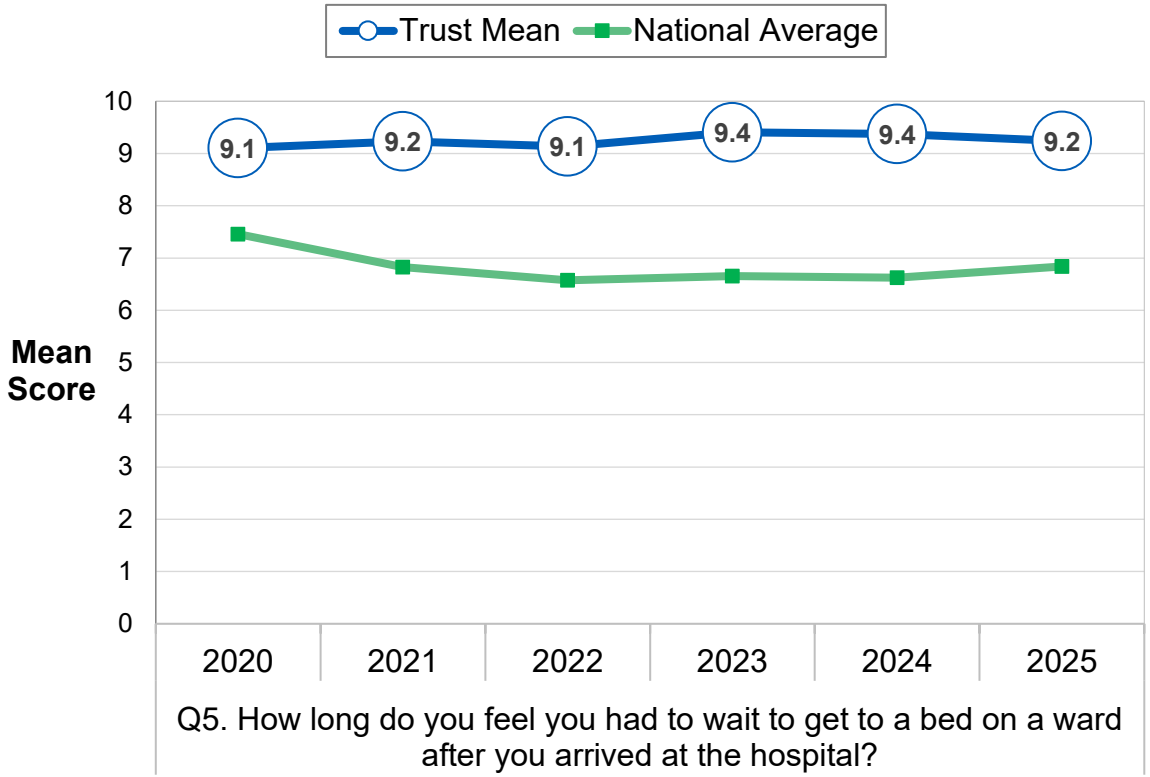


Significant change 2025 vs 2024	No change

Answered by those whose most recent hospital admission was waiting list or planned in advance.
Number of respondents: 2024: 382; 2025: 326

Section 1. Admission to hospital

Question scores

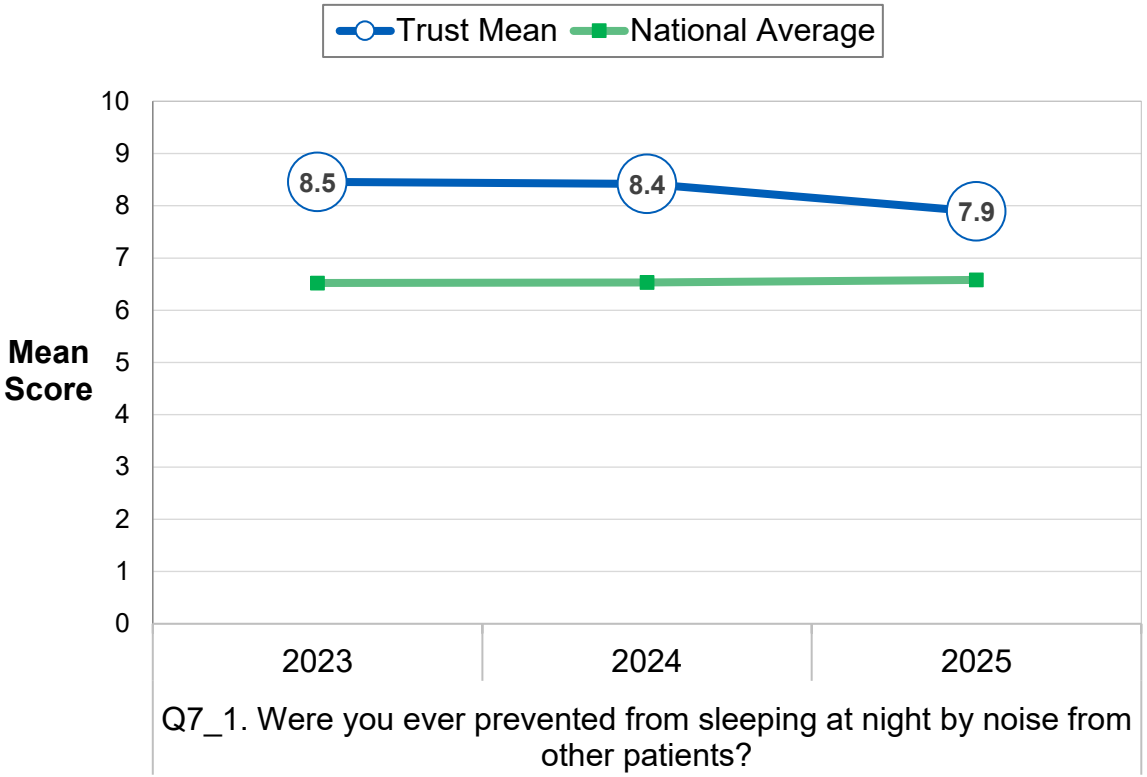


Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2020: 622; 2021: 535; 2022: 524; 2023: 516; 2024: 555; 2025: 486

Section 2. The hospital and ward

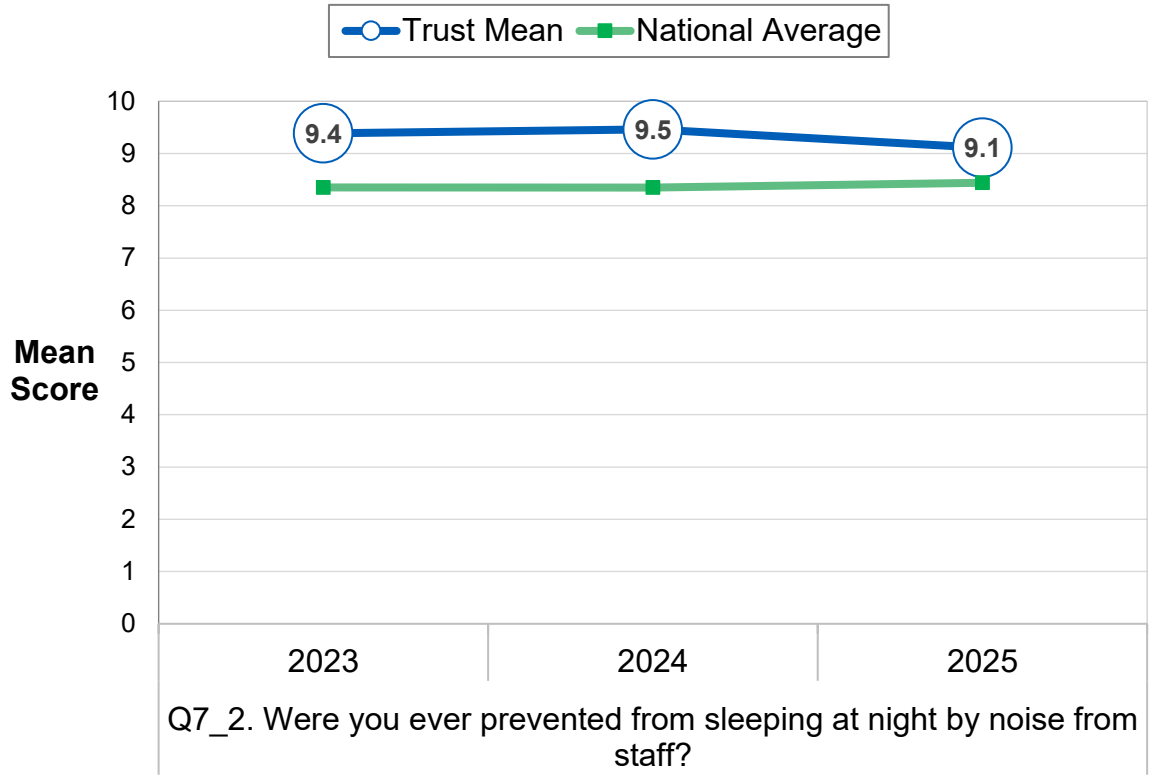
Question scores



Q7_1. Were you ever prevented from sleeping at night by noise from other patients?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2023: 514; 2024: 556; 2025: 490



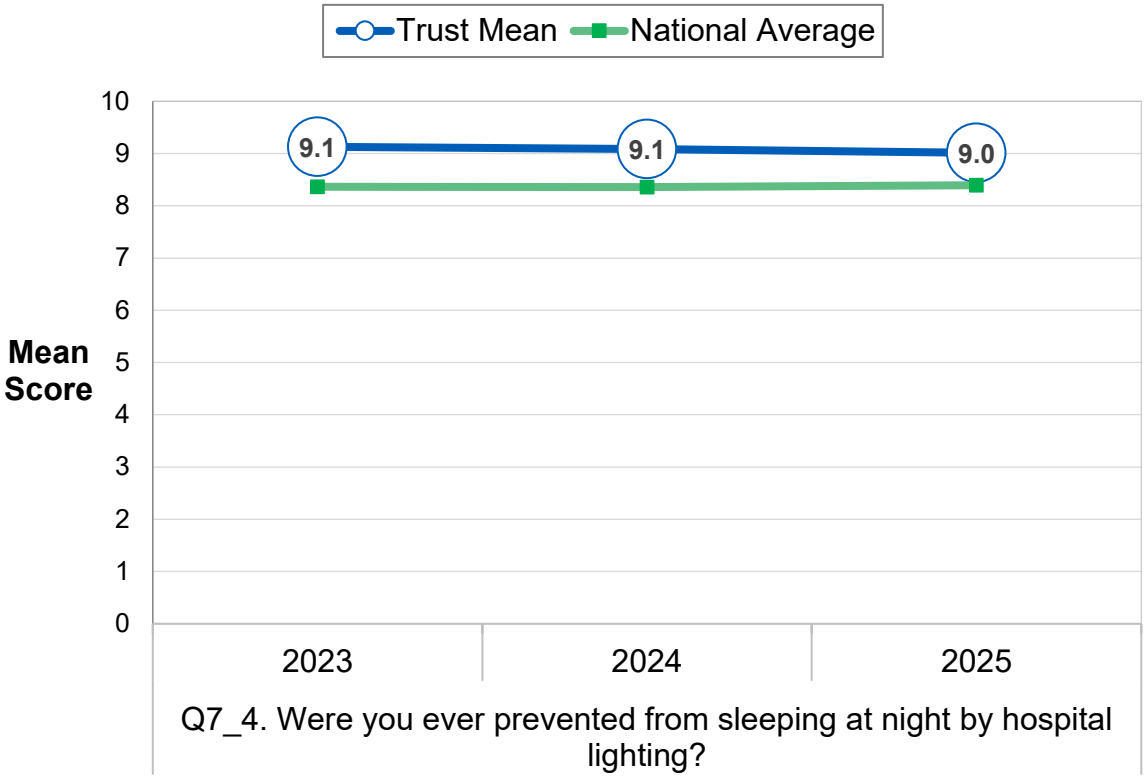
Q7_2. Were you ever prevented from sleeping at night by noise from staff?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2023: 514; 2024: 556; 2025: 490

Section 2. The hospital and ward (continued)

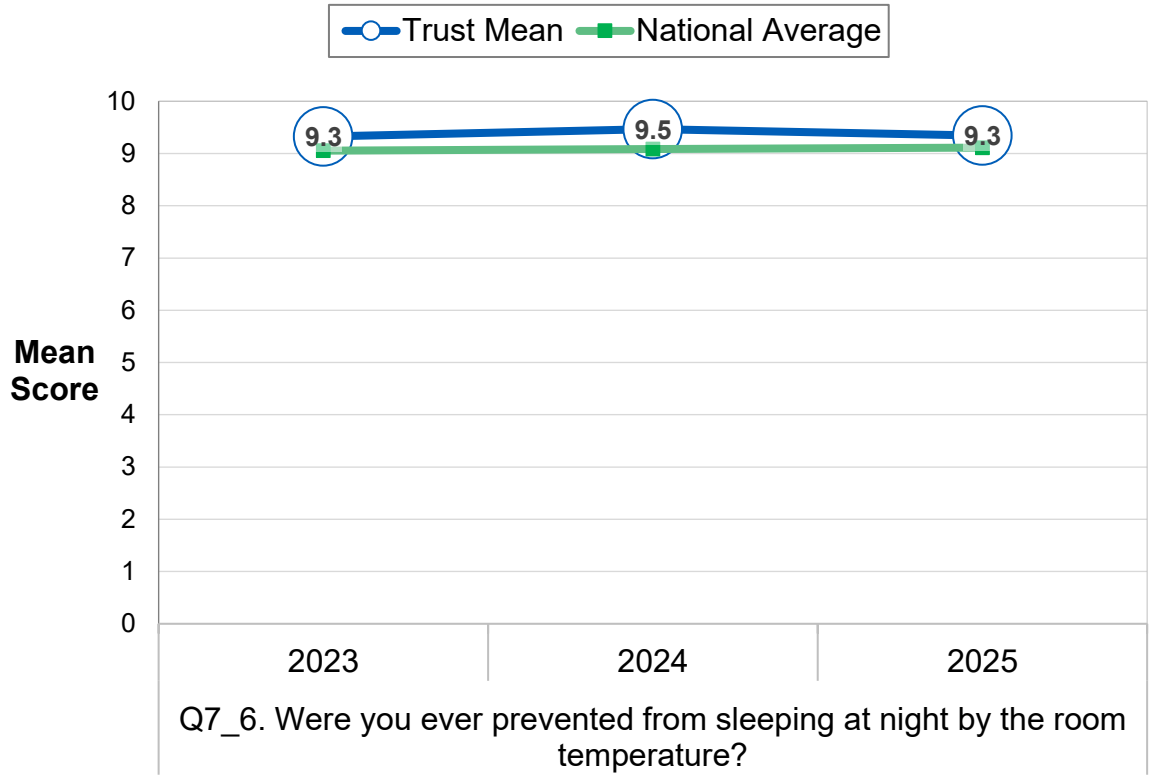
Question scores



Q7_4. Were you ever prevented from sleeping at night by hospital lighting?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2023: 514; 2024: 556; 2025: 490



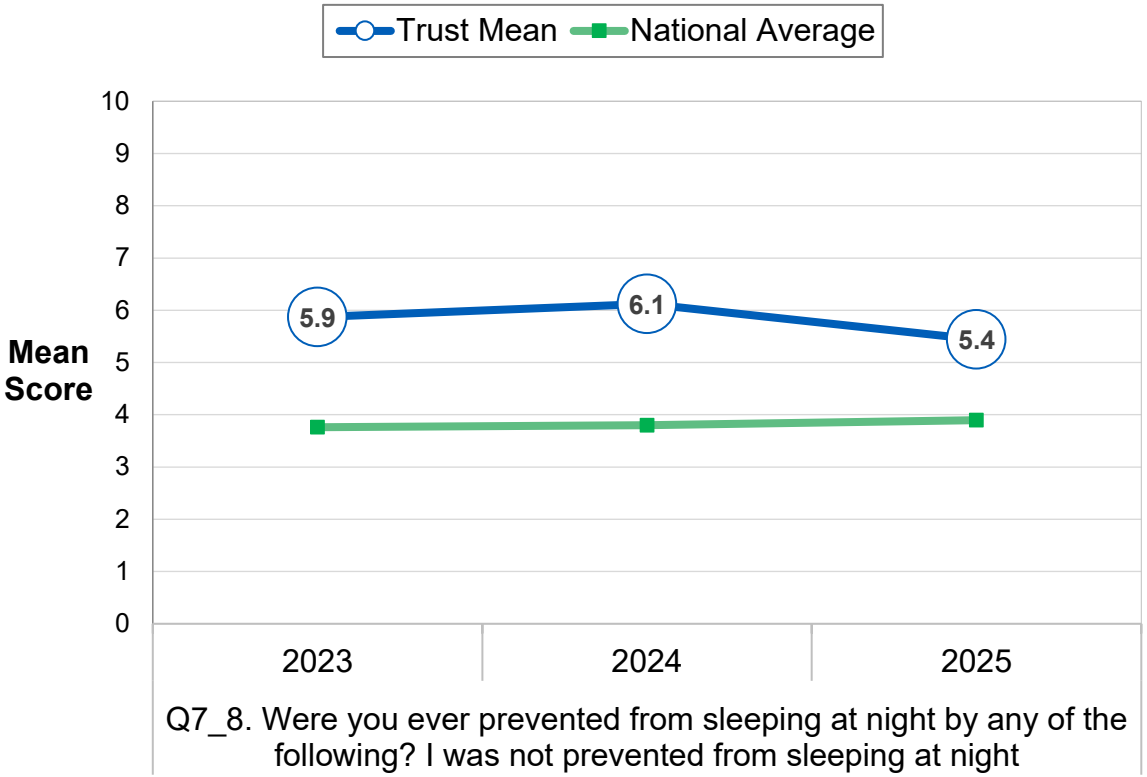
Q7_6. Were you ever prevented from sleeping at night by the room temperature?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2023: 514; 2024: 556; 2025: 490

Section 2. The hospital and ward (continued)

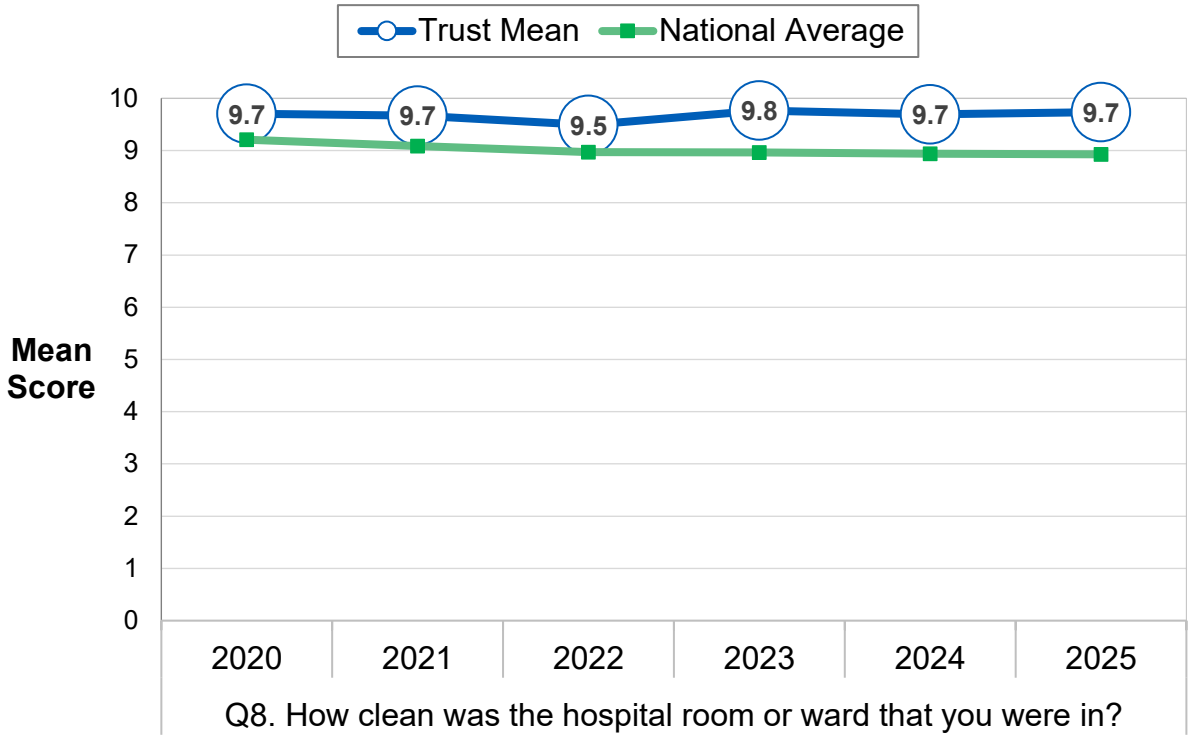
Question scores



Q7_8. Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping at night

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2023: 514; 2024: 556; 2025: 490



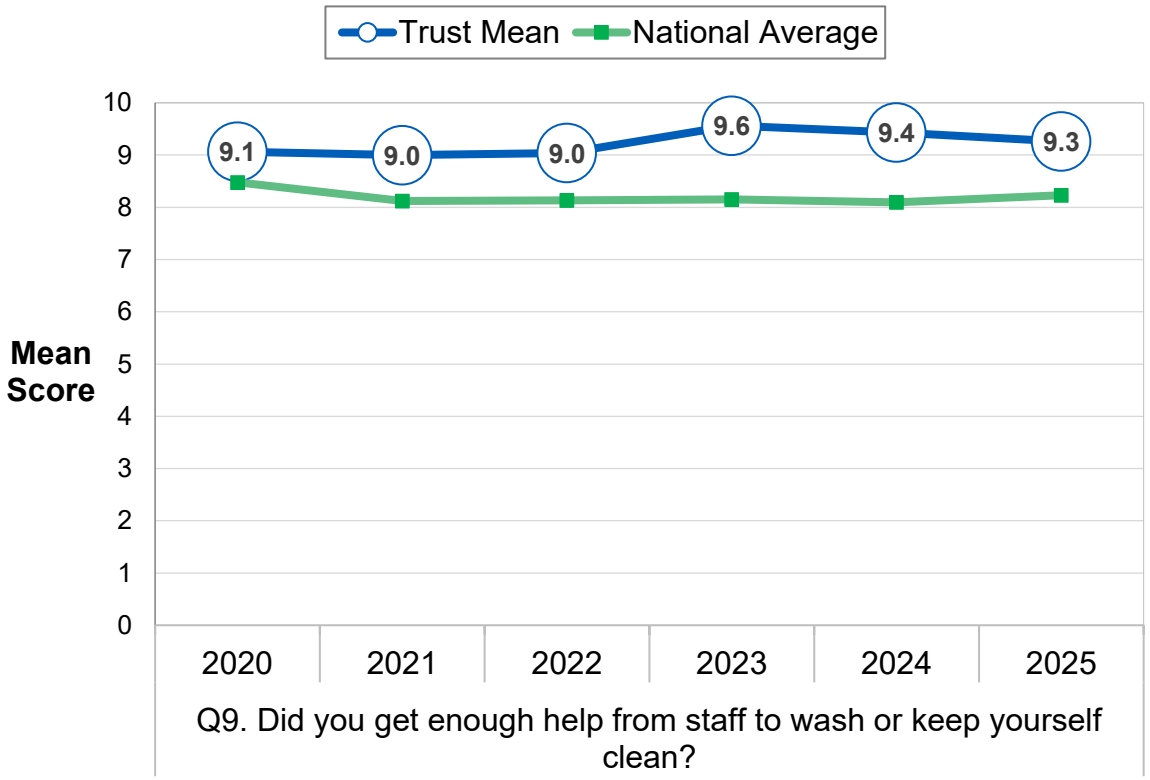
Q8. How clean was the hospital room or ward that you were in?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2020: 632; 2021: 535; 2022: 531; 2023: 518; 2024: 557; 2025: 493

Section 3. Basic needs

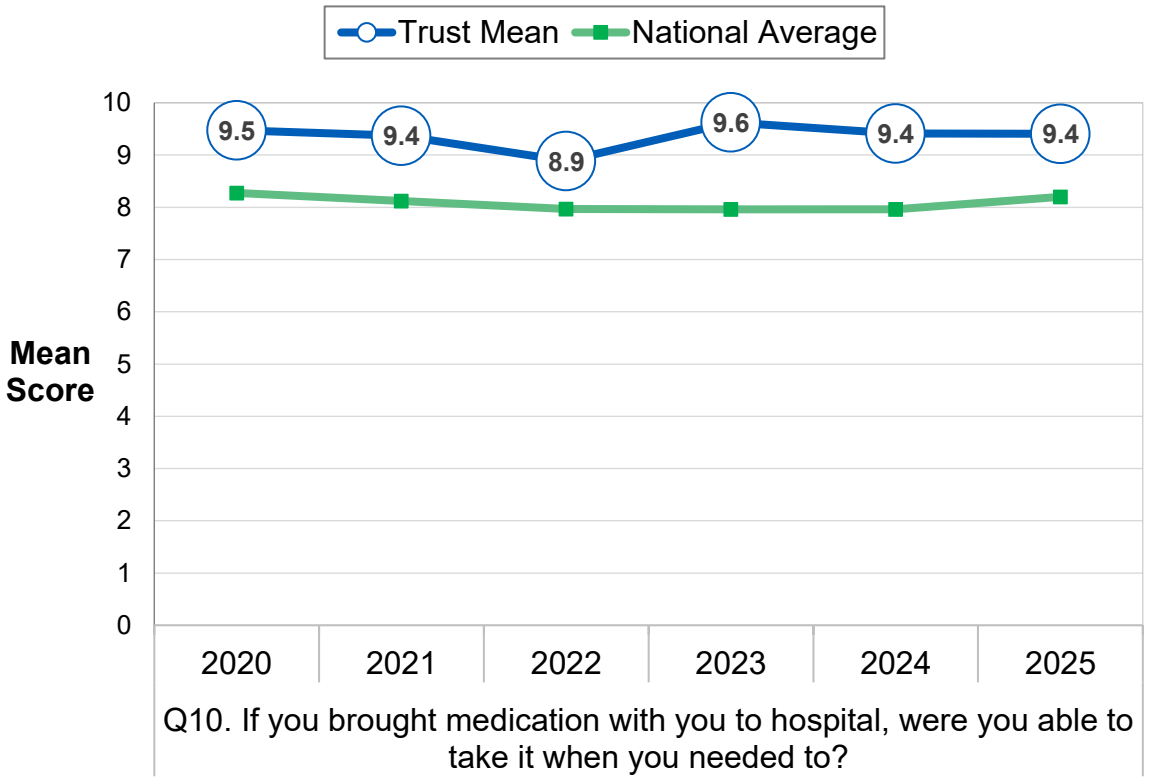
Question scores



Q9. Did you get enough help from staff to wash or keep yourself clean?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated they did not need help have been excluded.
Number of respondents: 2020: 361; 2021: 328; 2022: 319; 2023: 301; 2024: 331; 2025: 304



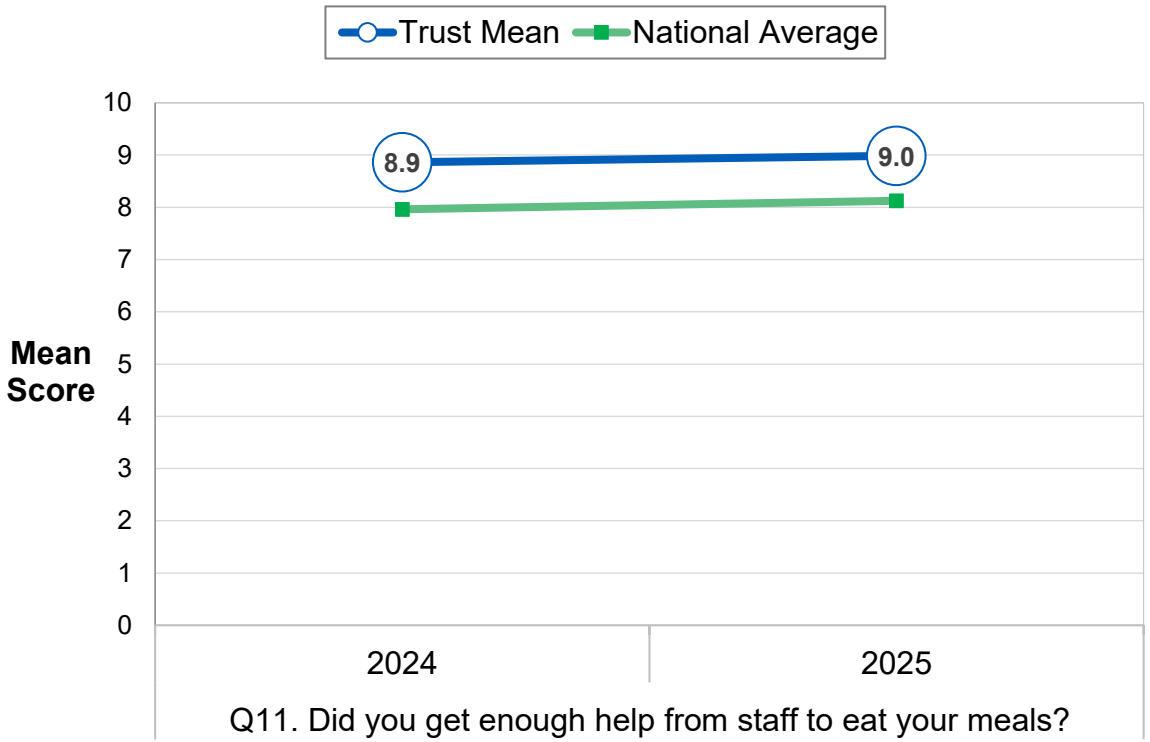
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated that they had to stop taking medication as part of their treatment or did not bring medication with them to hospital have been excluded.
Number of respondents: 2020: 355; 2021: 314; 2022: 319; 2023: 308; 2024: 336; 2025: 297

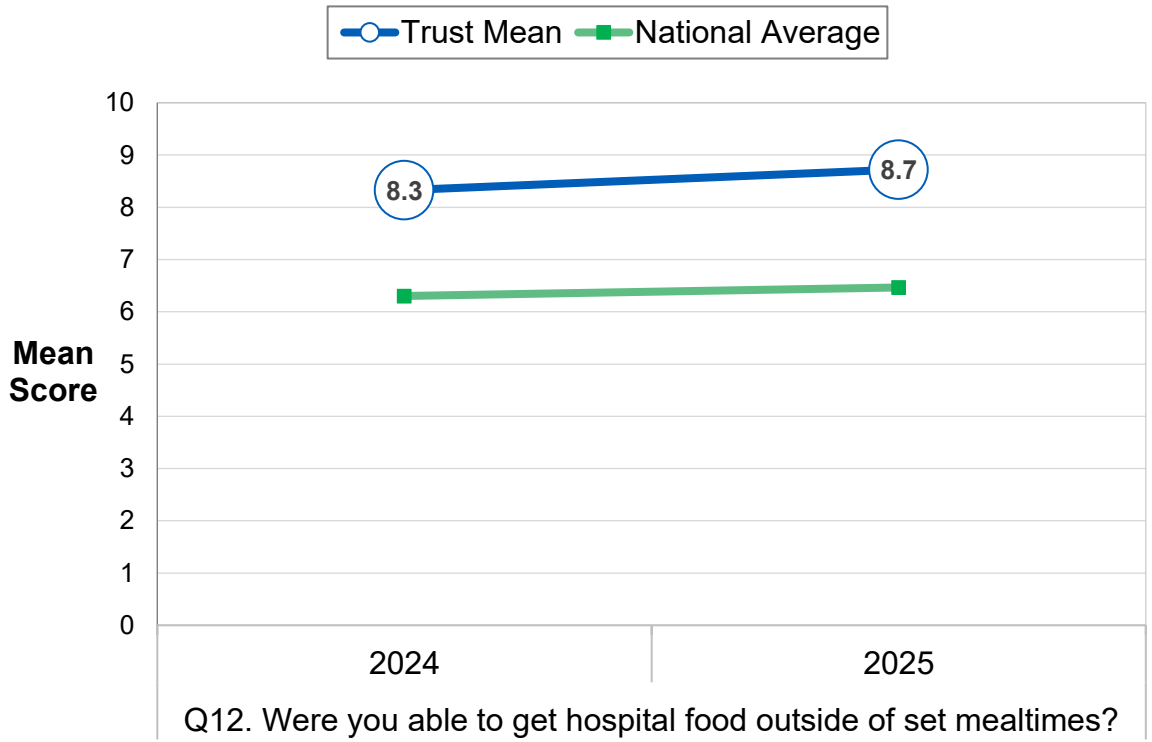
Section 3. Basic needs (continued)

Question scores



Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated they did not need help have been excluded.
Number of respondents: 2024: 202; 2025: 161

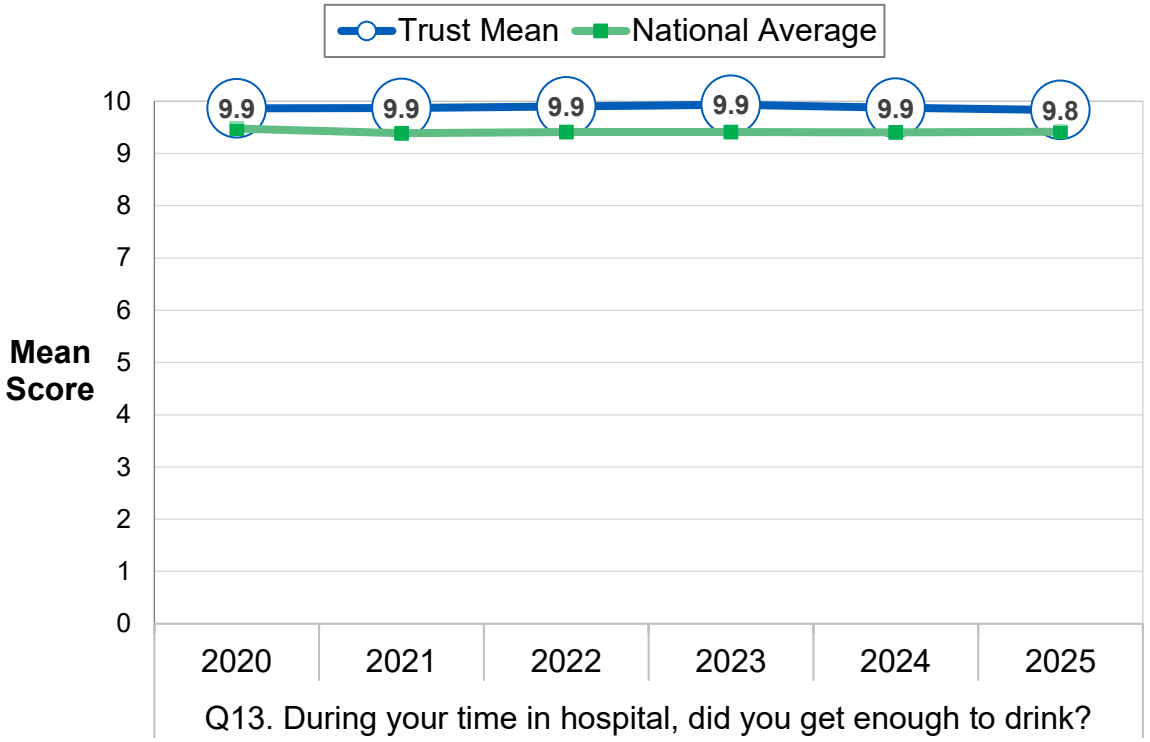


Significant change 2025 vs 2024	No change

Answered by all. Respondents who stated they did not need this, didn't know, or couldn't remember have been excluded.
Number of respondents: 2024: 214; 2025: 169

Section 3. Basic needs (continued)

Question scores

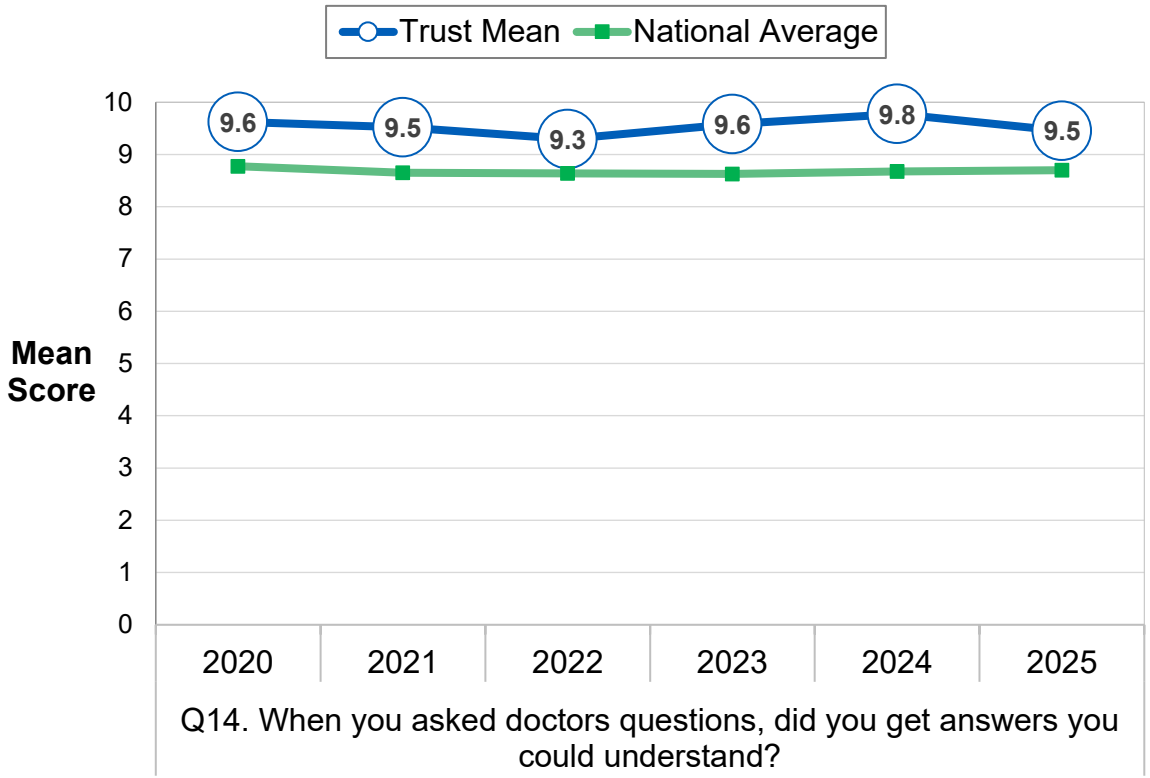


Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2020: 600; 2021: 525; 2022: 515; 2023: 509; 2024: 545; 2025: 470

Section 4. Doctors

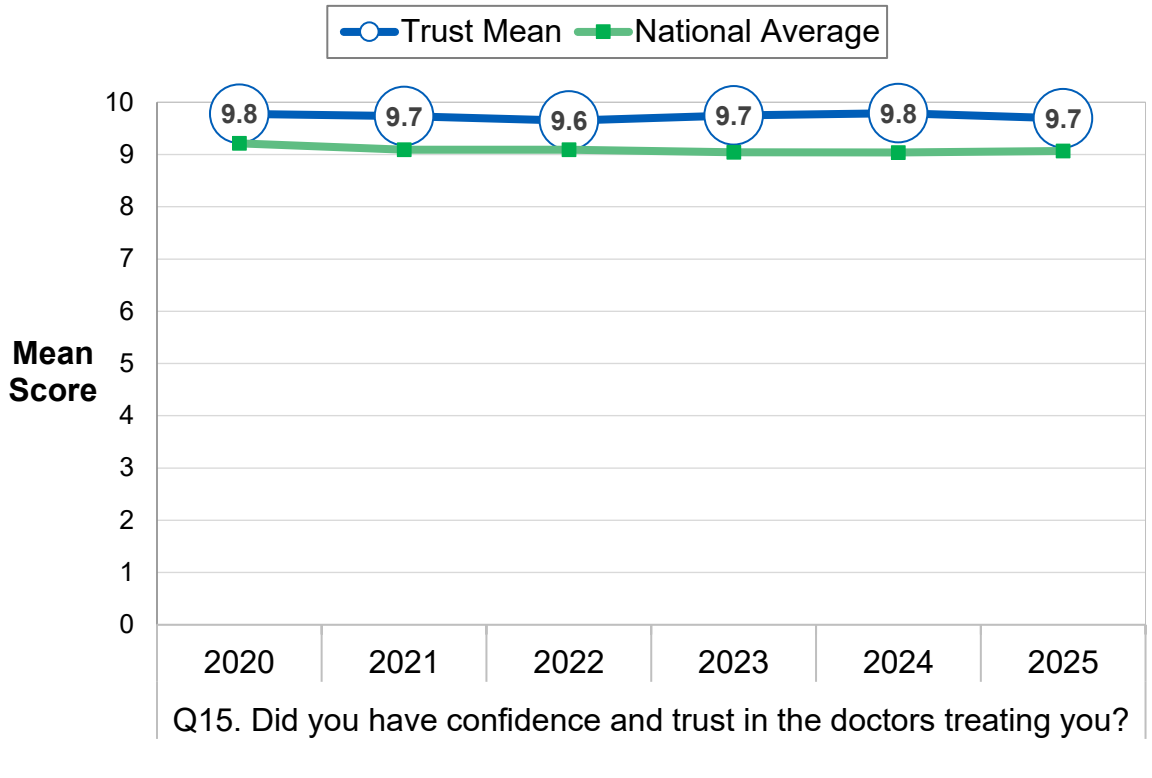
Question scores



Q14. When you asked doctors questions, did you get answers you could understand?

Significant change 2025 vs 2024	Decrease
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated they did not have any questions or feel able to ask questions have been excluded.
Number of respondents: 2020: 561; 2021: 476; 2022: 473; 2023: 459; 2024: 504; 2025: 447



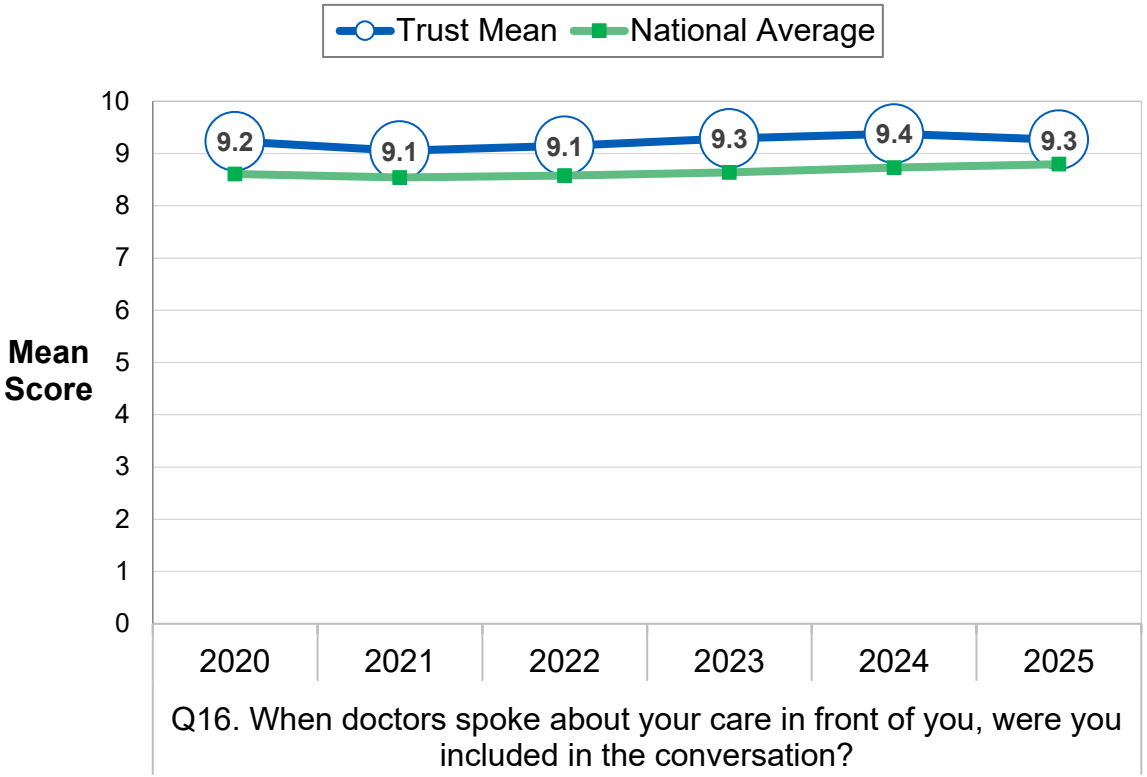
Q15. Did you have confidence and trust in the doctors treating you?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2020: 623; 2021: 535; 2022: 526; 2023: 519; 2024: 554; 2025: 491

Section 4. Doctors (continued)

Question scores

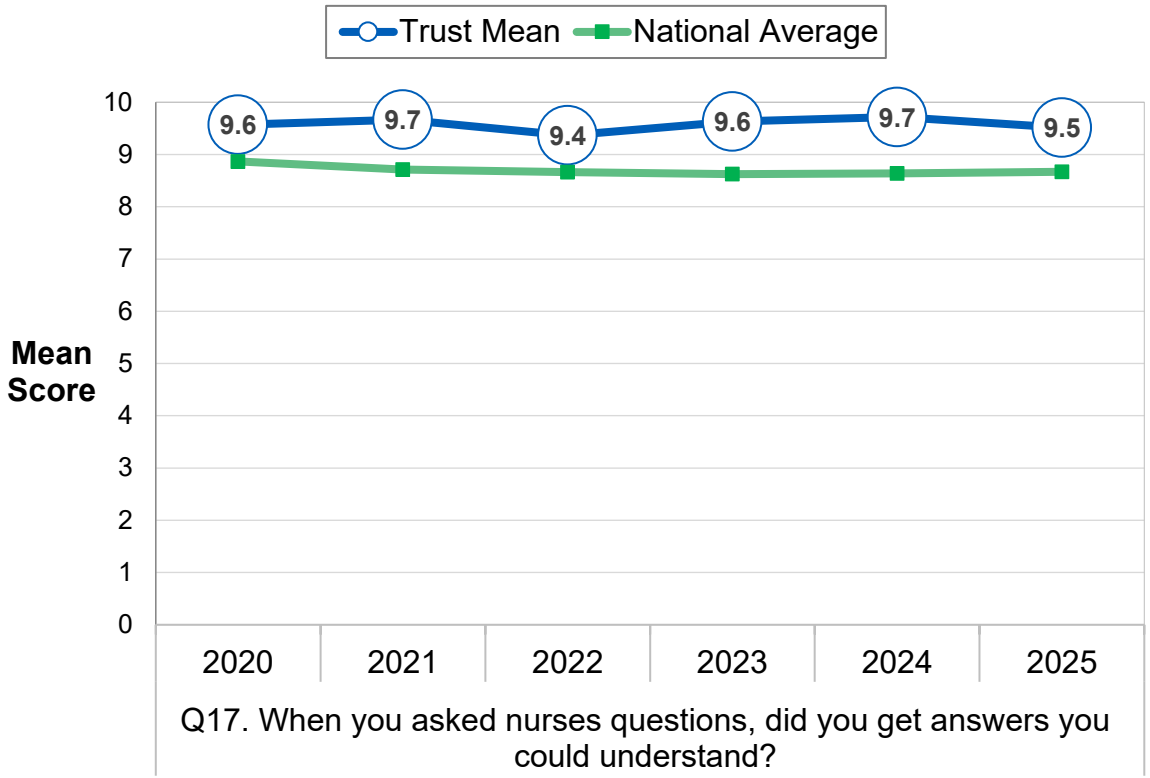


Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2020: 612; 2021: 526; 2022: 518; 2023: 512; 2024: 545; 2025: 474

Section 5. Nurses

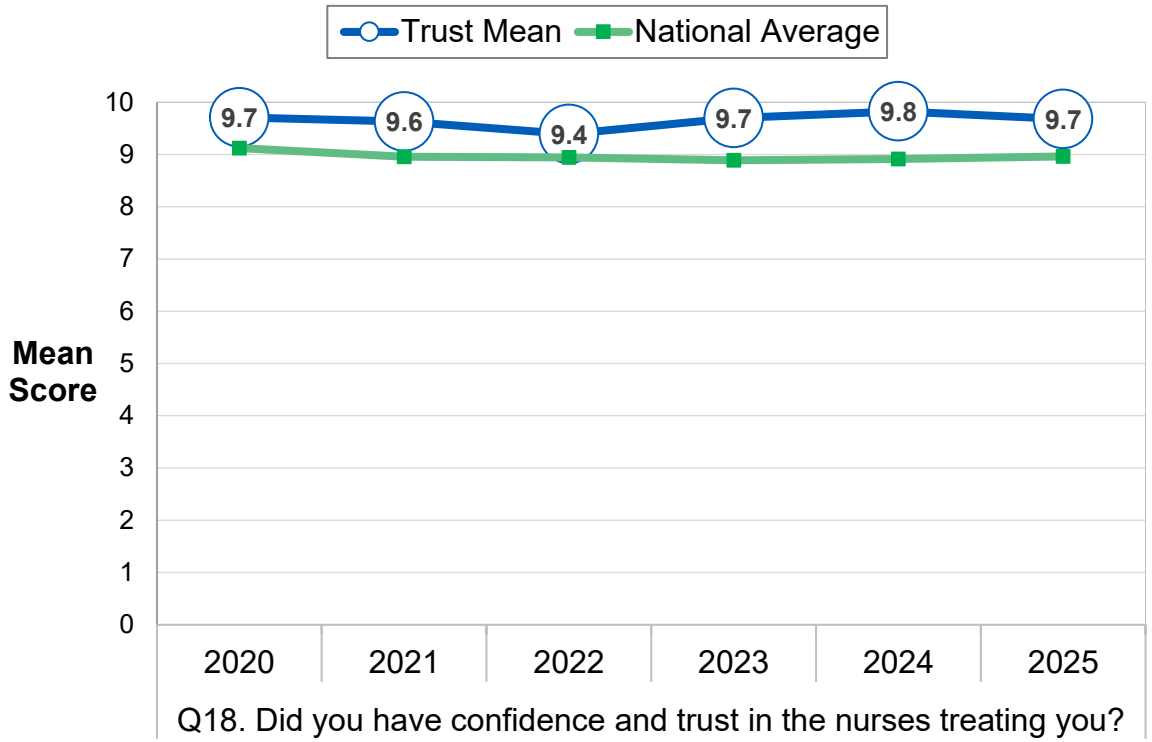
Question scores



Q17. When you asked nurses questions, did you get answers you could understand?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated they did not have any questions or feel able to ask questions have been excluded.
Number of respondents: 2020: 603; 2021: 511; 2022: 513; 2023: 494; 2024: 530; 2025: 463



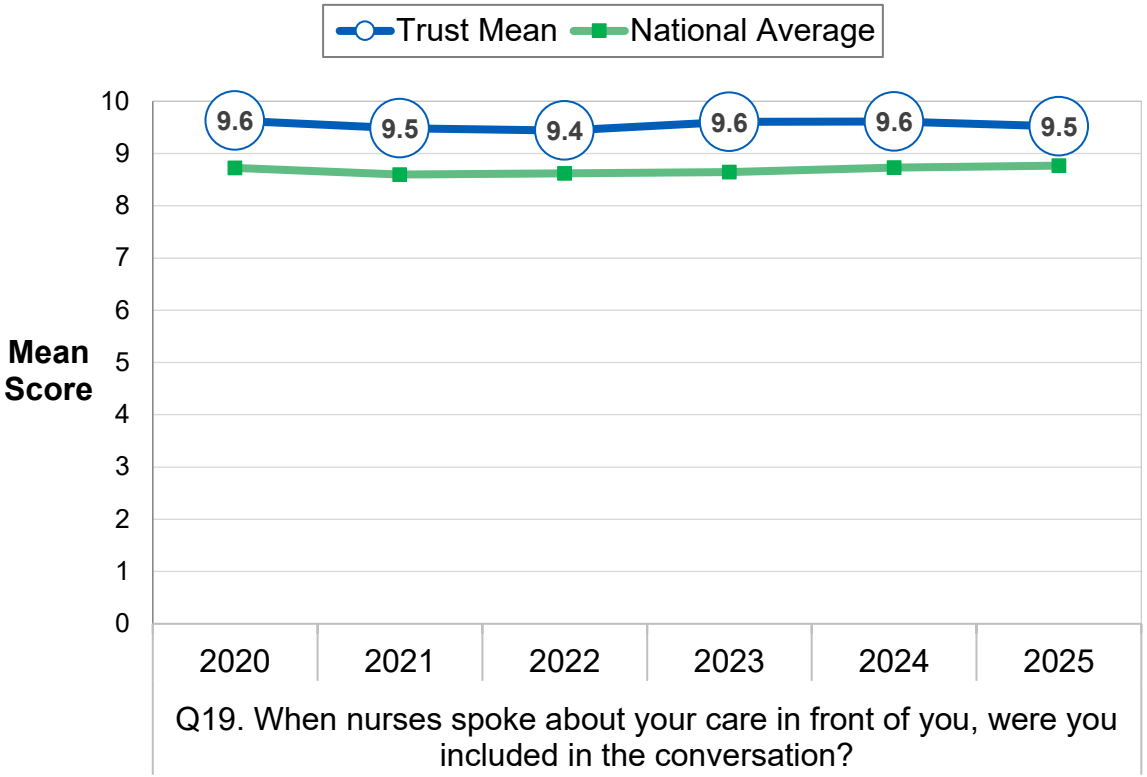
Q18. Did you have confidence and trust in the nurses treating you?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2020: 633; 2021: 539; 2022: 531; 2023: 524; 2024: 557; 2025: 494

Section 5. Nurses (continued)

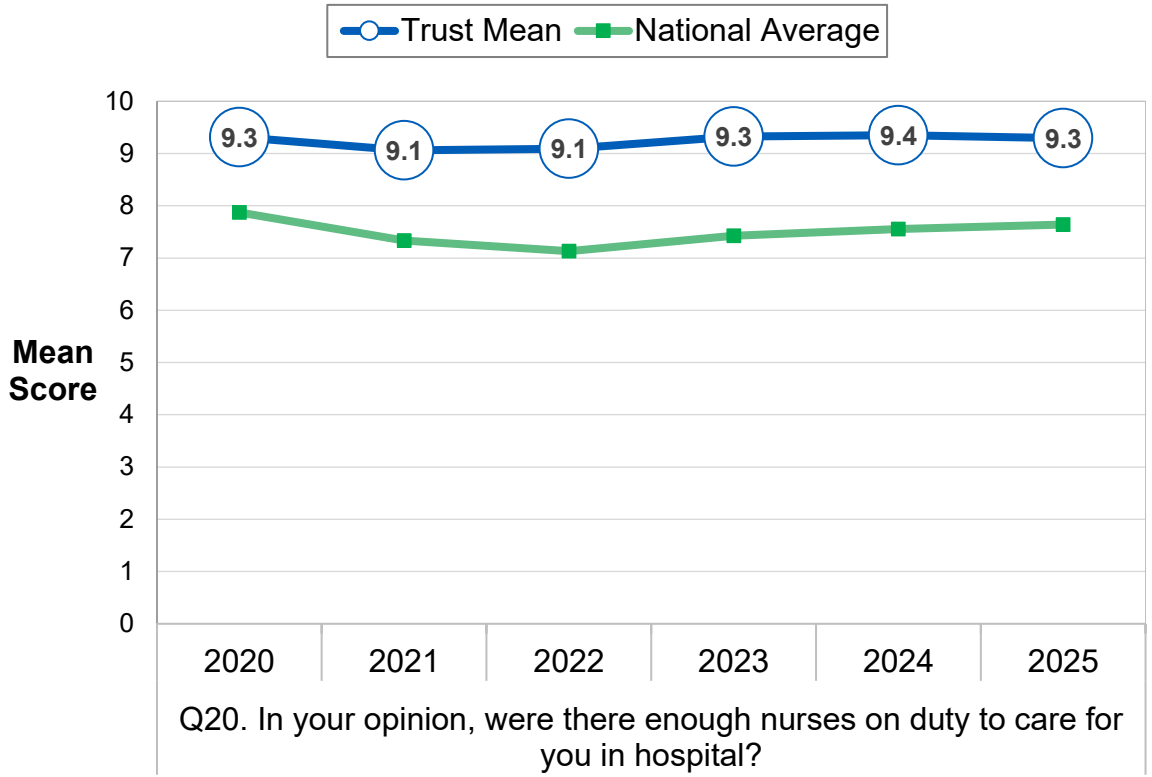
Question scores



Q19. When nurses spoke about your care in front of you, were you included in the conversation?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2020: 628; 2021: 533; 2022: 523; 2023: 514; 2024: 548; 2025: 487



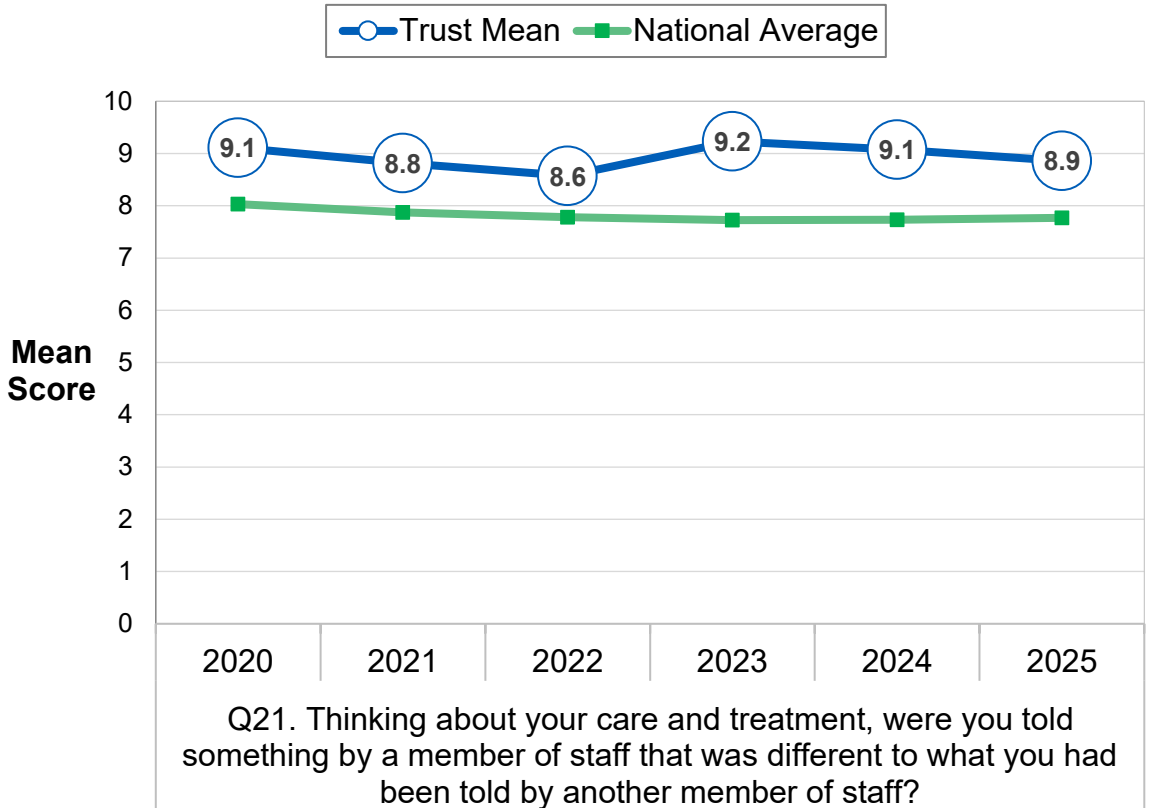
Q20. In your opinion, were there enough nurses on duty to care for you in hospital?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all
Number of respondents: 2020: 627; 2021: 534; 2022: 528; 2023: 516; 2024: 557; 2025: 491

Section 6. Your care and treatment

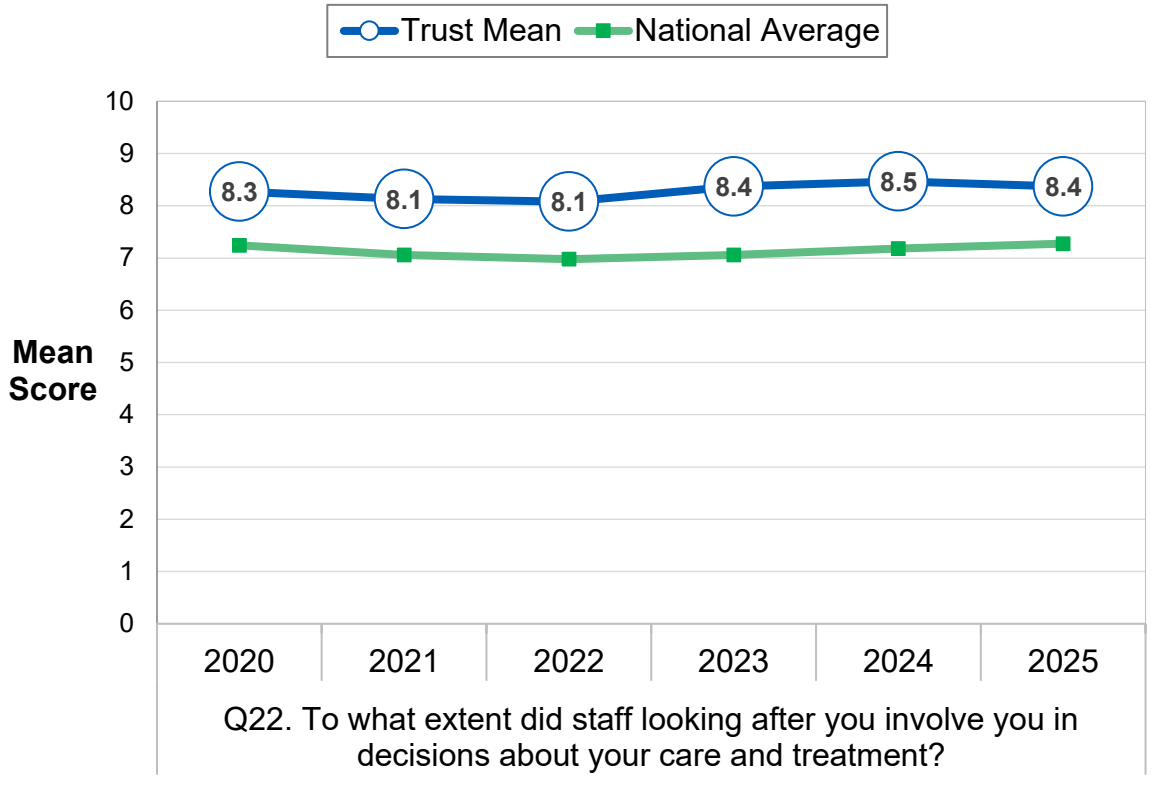
Question scores



Q21. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated they didn't know or couldn't remember have been excluded.
Number of respondents: 2020: 586; 2021: 496; 2022: 480; 2023: 477; 2024: 503; 2025: 458



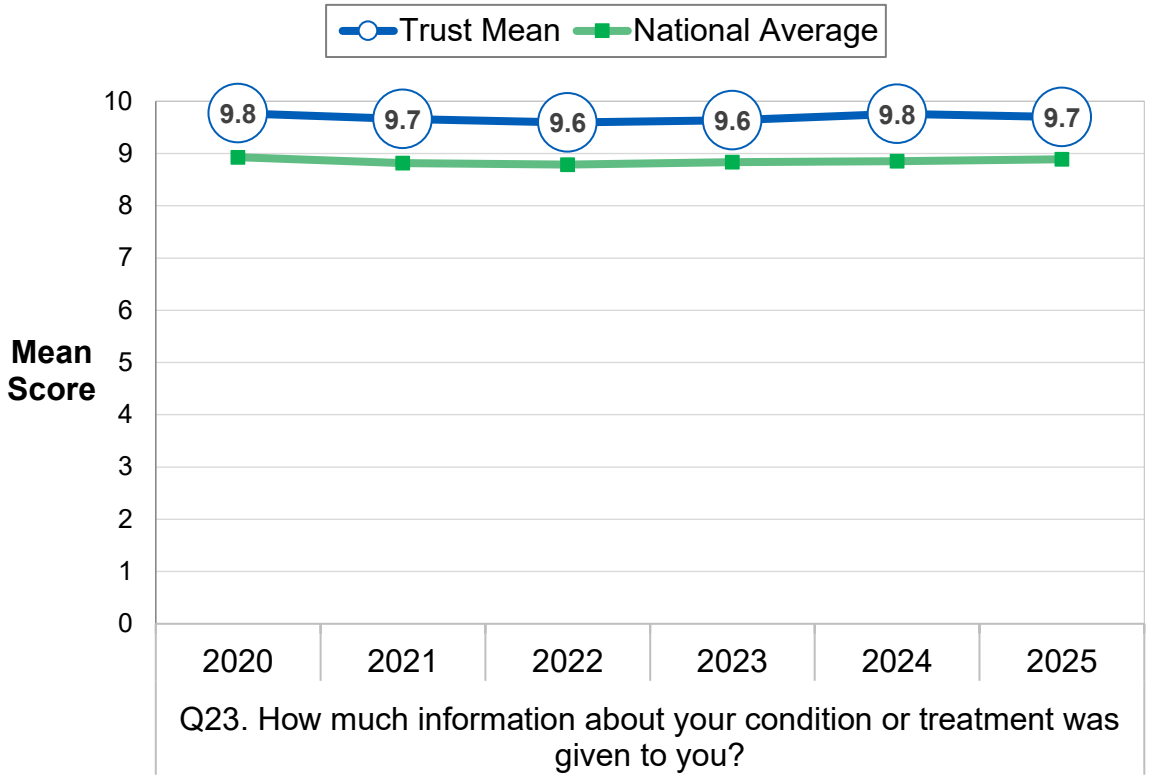
Q22. To what extent did staff looking after you involve you in decisions about your care and treatment?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated they were not able to be or didn't want to be involved have been excluded.
Number of respondents: 2020: 605; 2021: 510; 2022: 506; 2023: 493; 2024: 522; 2025: 465

Section 6. Your care and treatment (continued)

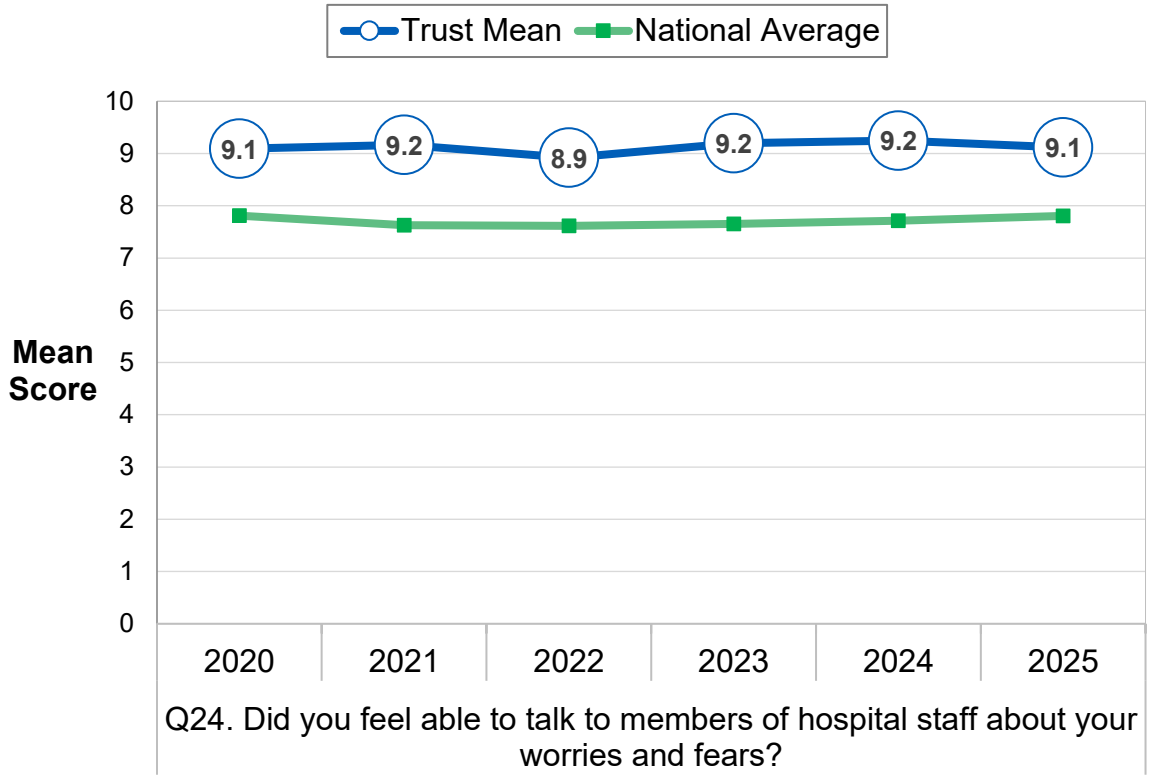
Question scores



Q23. How much information about your condition or treatment was given to you?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated they didn't know or couldn't remember have been excluded.
Number of respondents: 2020: 626; 2021: 530; 2022: 523; 2023: 512; 2024: 546; 2025: 485



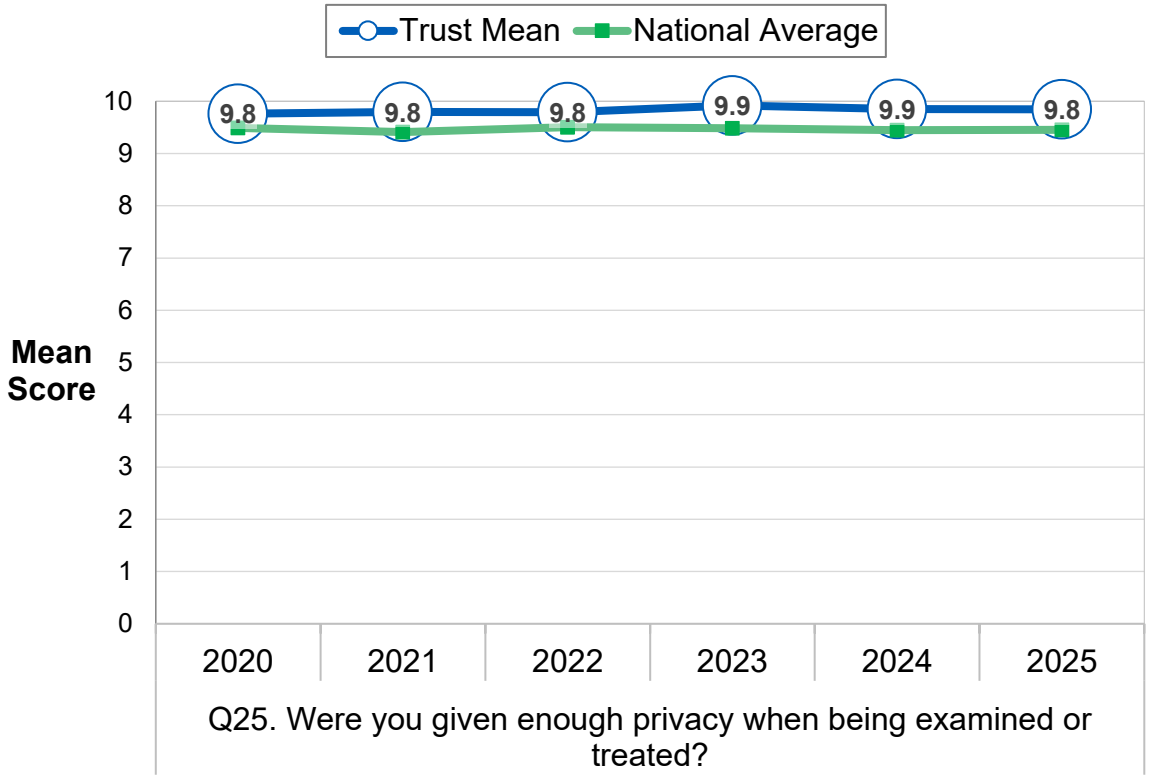
Q24. Did you feel able to talk to members of hospital staff about your worries and fears?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated they had no worries or fears have been excluded.
Number of respondents: 2020: 514; 2021: 446; 2022: 444; 2023: 414; 2024: 444; 2025: 390

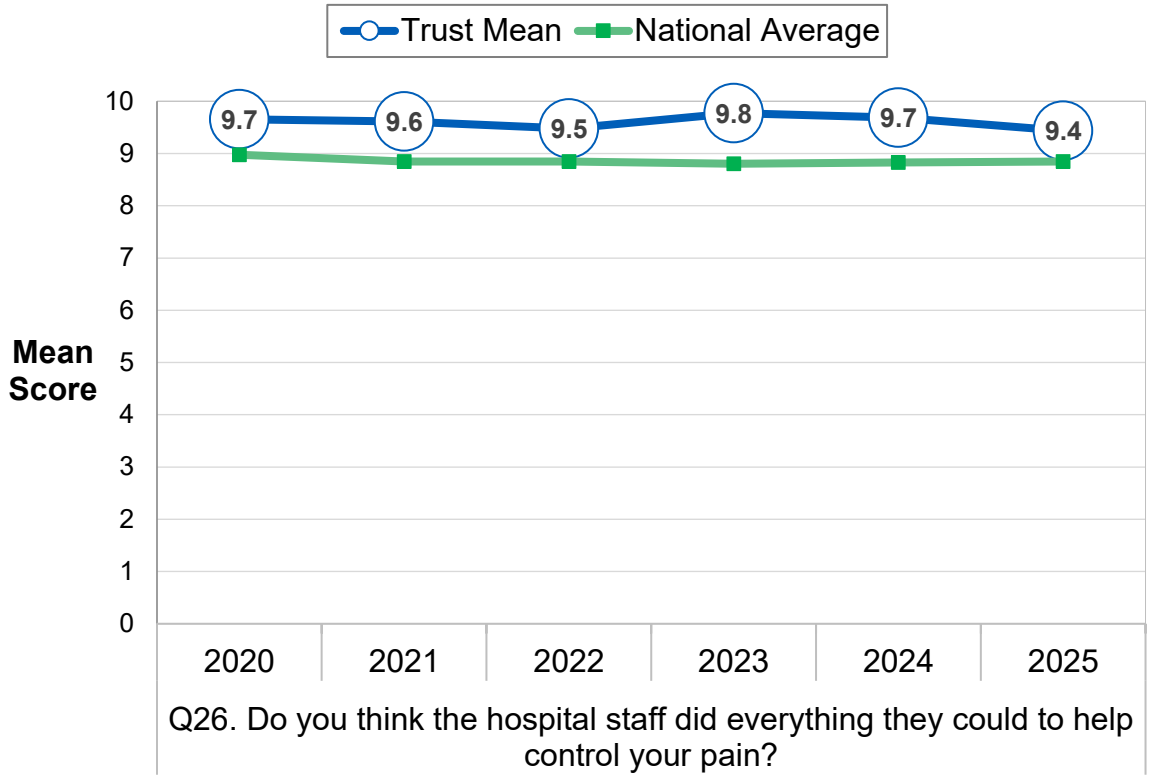
Section 6. Your care and treatment (continued)

Question scores



Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated they did not want this, didn't know or couldn't remember have been excluded.
Number of respondents: 2020: 626; 2021: 529; 2022: 524; 2023: 509; 2024: 552; 2025: 482

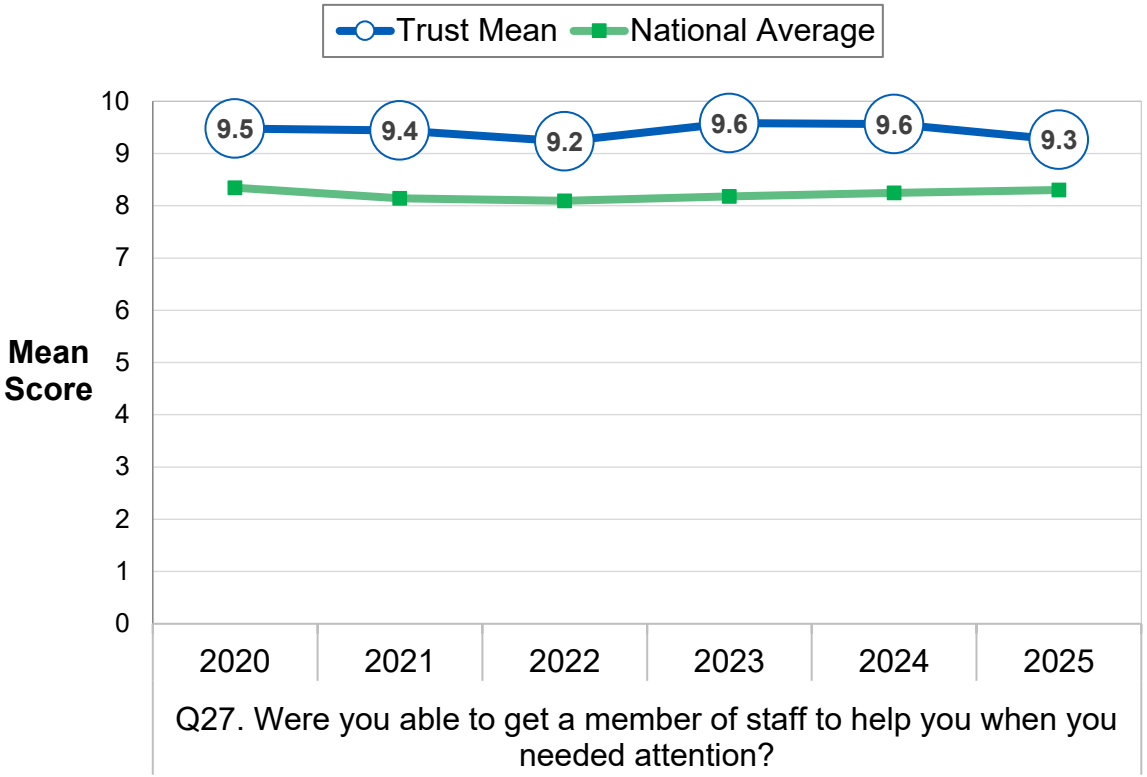


Significant change 2025 vs 2024	Decrease
Significant change 2025 vs 2023	Decrease

Answered by all. Respondents who stated they were not in any pain, didn't know or couldn't remember have been excluded.
Number of respondents: 2020: 490; 2021: 445; 2022: 399; 2023: 376; 2024: 426; 2025: 380

Section 6. Your care and treatment (continued)

Question scores

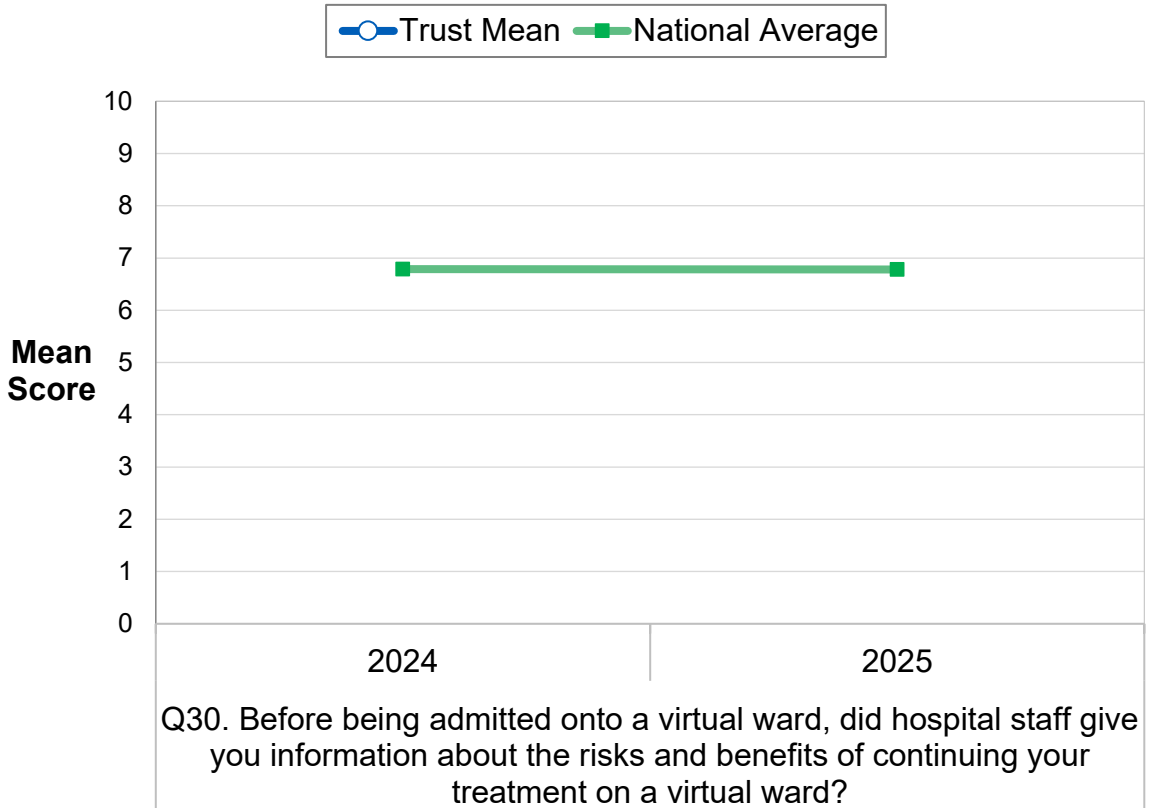


Significant change 2025 vs 2024	Decrease
Significant change 2025 vs 2023	Decrease

Answered by all. Respondents who stated they did not need attention have been excluded.
Number of respondents: 2020: 526; 2021: 458; 2022: 443; 2023: 427; 2024: 465; 2025: 410

Section 8. Virtual wards

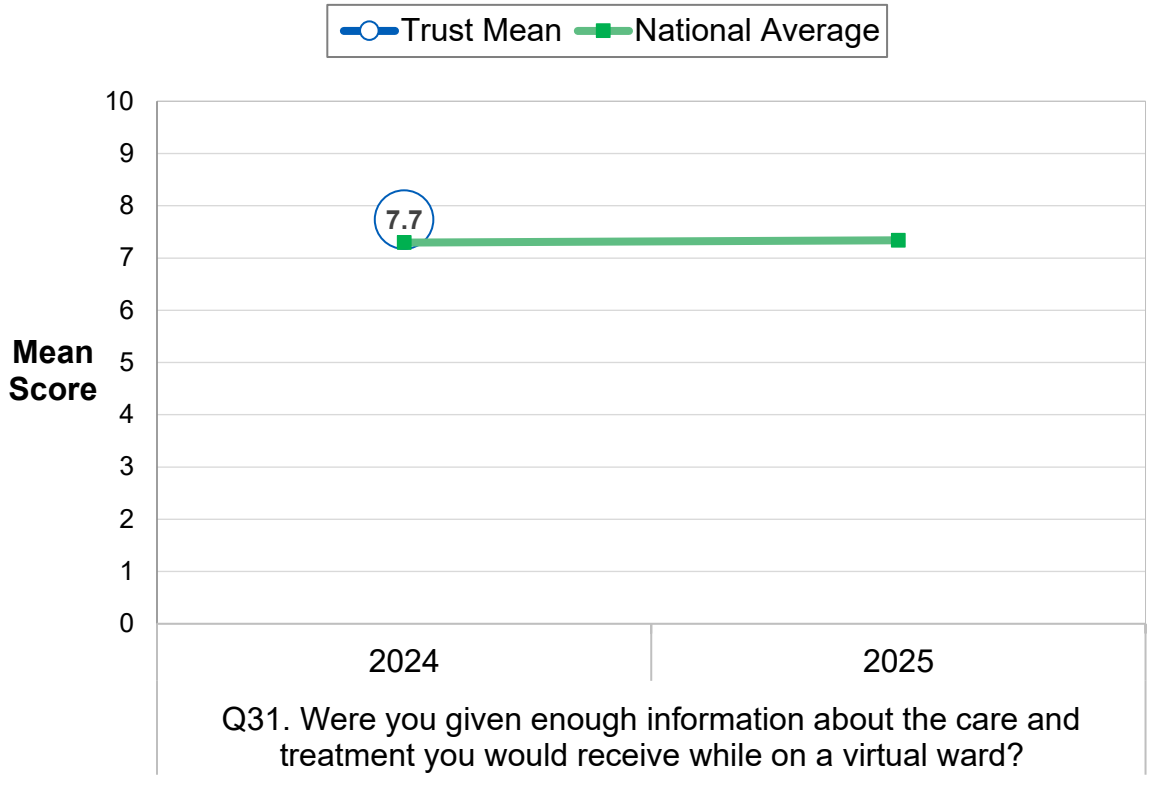
Question scores



Q30. Before being admitted onto a virtual ward, did hospital staff give you information about the risks and benefits of continuing your treatment on a virtual ward?

Significant change 2025 vs 2024	-

Answered by all those that were admitted onto a virtual ward. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2024: - ; 2025: -



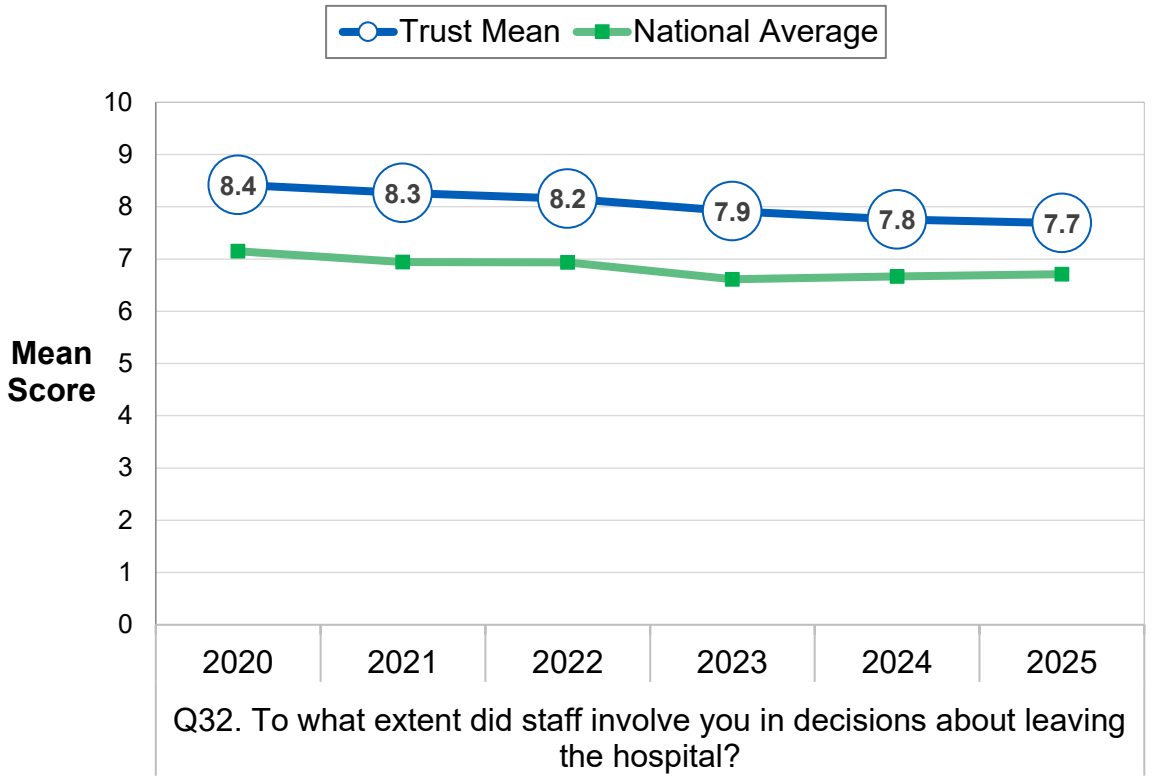
Q31. Were you given enough information about the care and treatment you would receive while on a virtual ward?

Significant change 2025 vs 2024	-

Answered by all those that were admitted onto a virtual ward. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2024: 31; 2025: -

Section 9. Leaving hospital

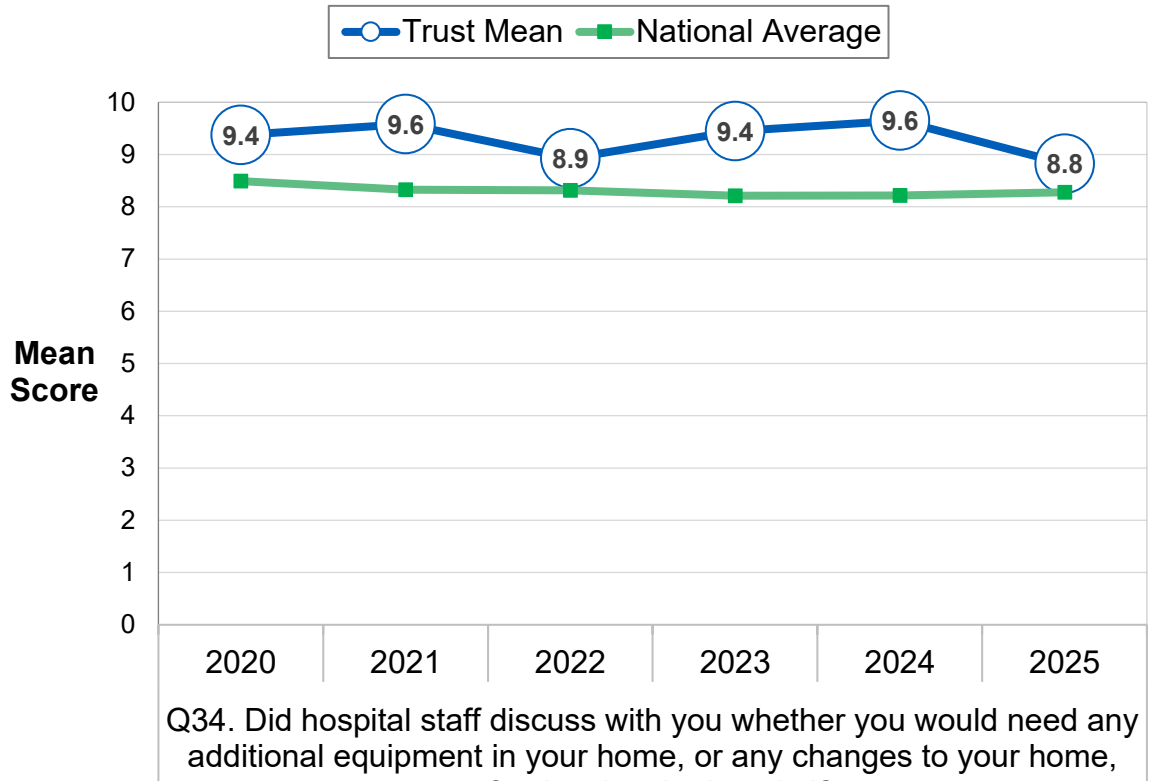
Question scores



Q32. To what extent did staff involve you in decisions about leaving the hospital?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated they did not want to be involved in decisions have been excluded.
Number of respondents: 2020: 606; 2021: 512; 2022: 499; 2023: 488; 2024: 524; 2025: 461



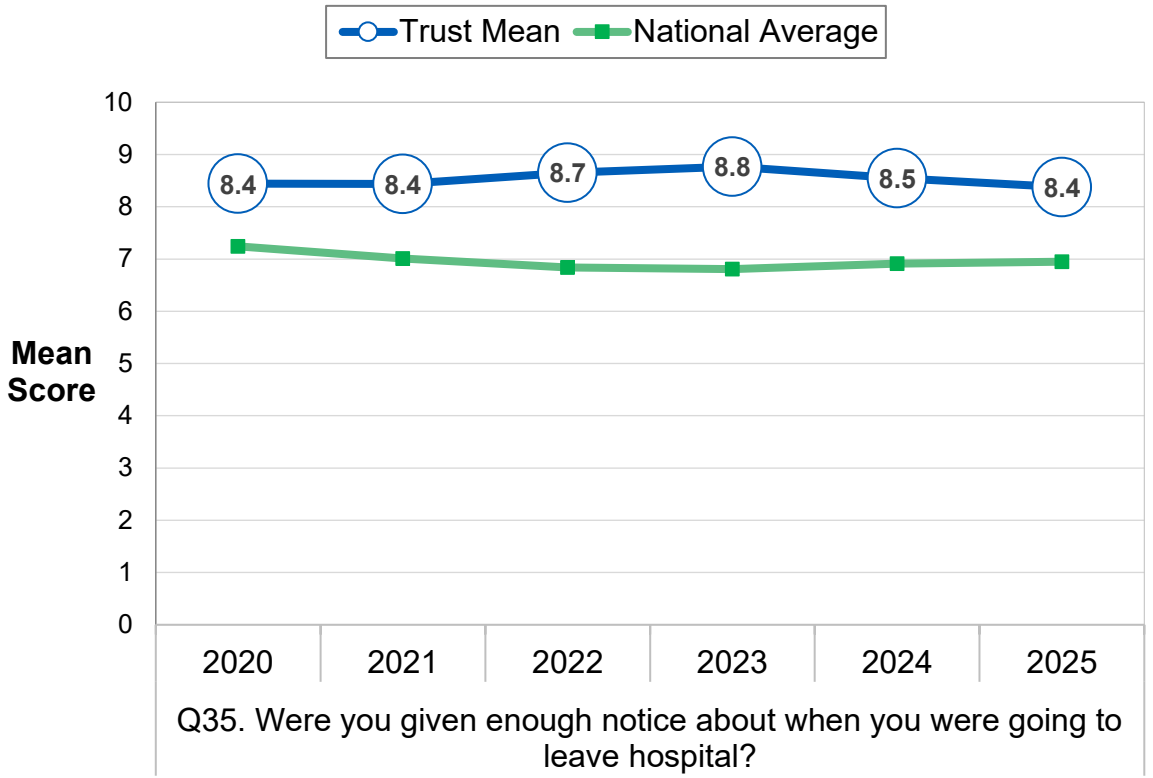
Q34. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?

Significant change 2025 vs 2024	Decrease
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated that it was not necessary to discuss it or that they didn't know or couldn't remember have been excluded.
Number of respondents: 2020: 157; 2021: 149; 2022: 126; 2023: 105; 2024: 120; 2025: 77

Section 9. Leaving hospital (continued)

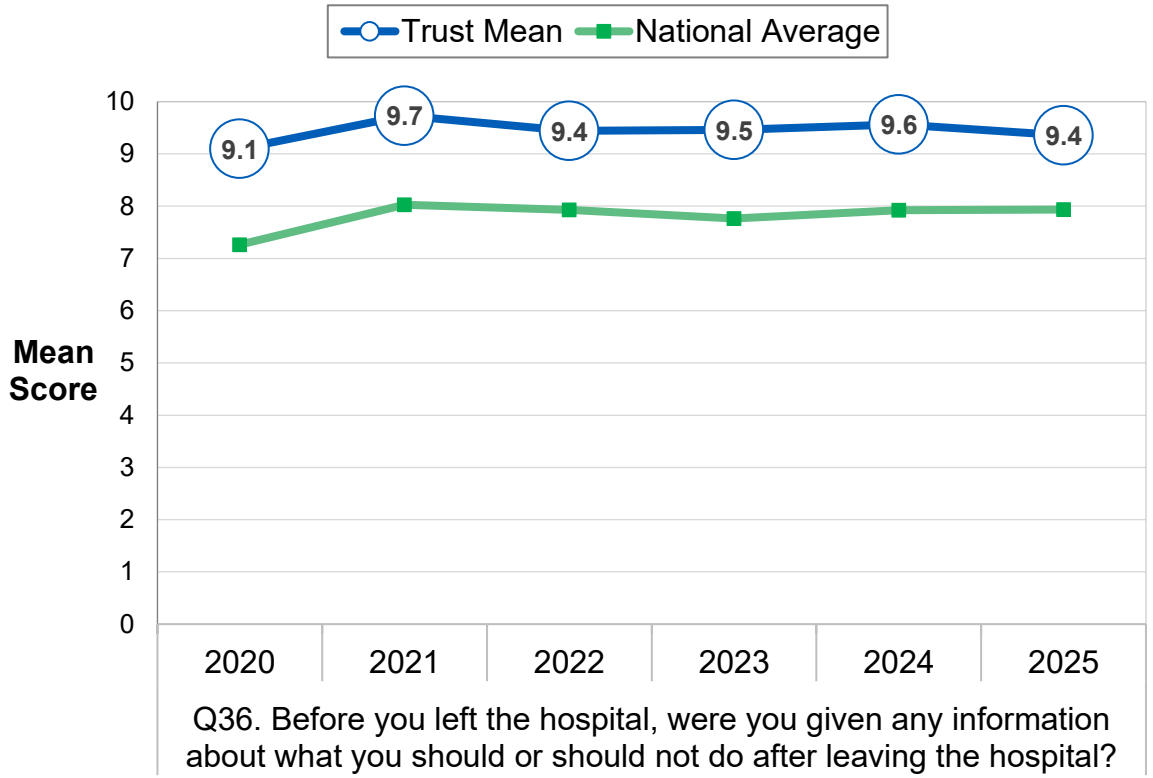
Question scores



Q35. Were you given enough notice about when you were going to leave hospital?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2020: 632; 2021: 538; 2022: 533; 2023: 519; 2024: 559; 2025: 493



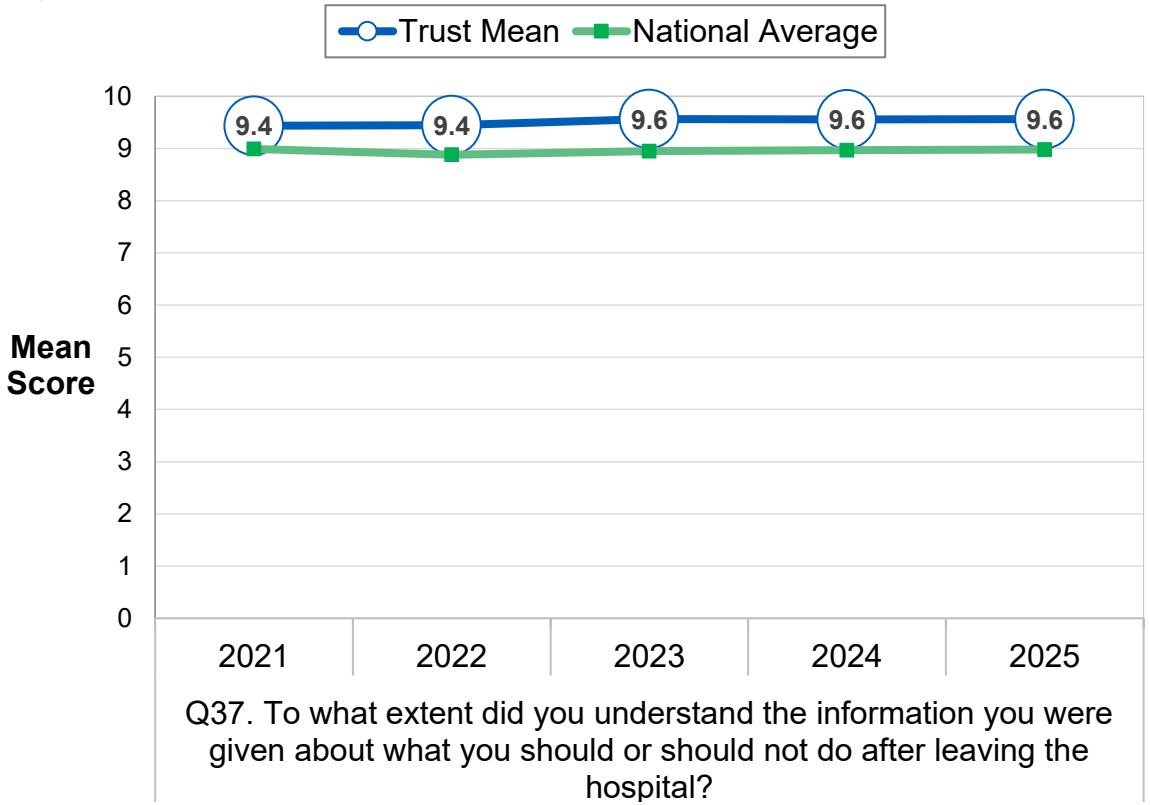
Q36. Before you left the hospital, were you given any information about what you should or should not do after leaving the hospital?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2020: 590; 2021: 512; 2022: 511; 2023: 499; 2024: 544; 2025: 466

Section 9. Leaving hospital (continued)

Question scores

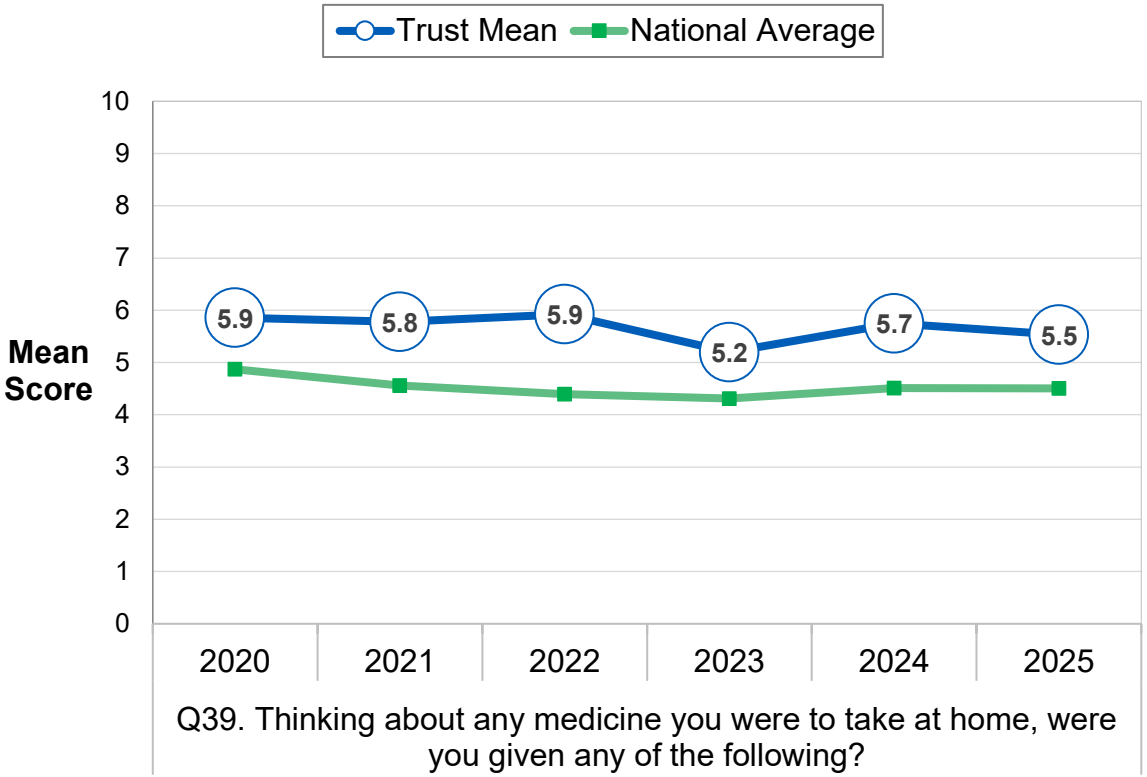


Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by those that were given information about what they should or should not do after leaving hospital. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2021: 480; 2022: 475; 2023: 453; 2024: 495; 2025: 426

Section 9. Leaving hospital (continued)

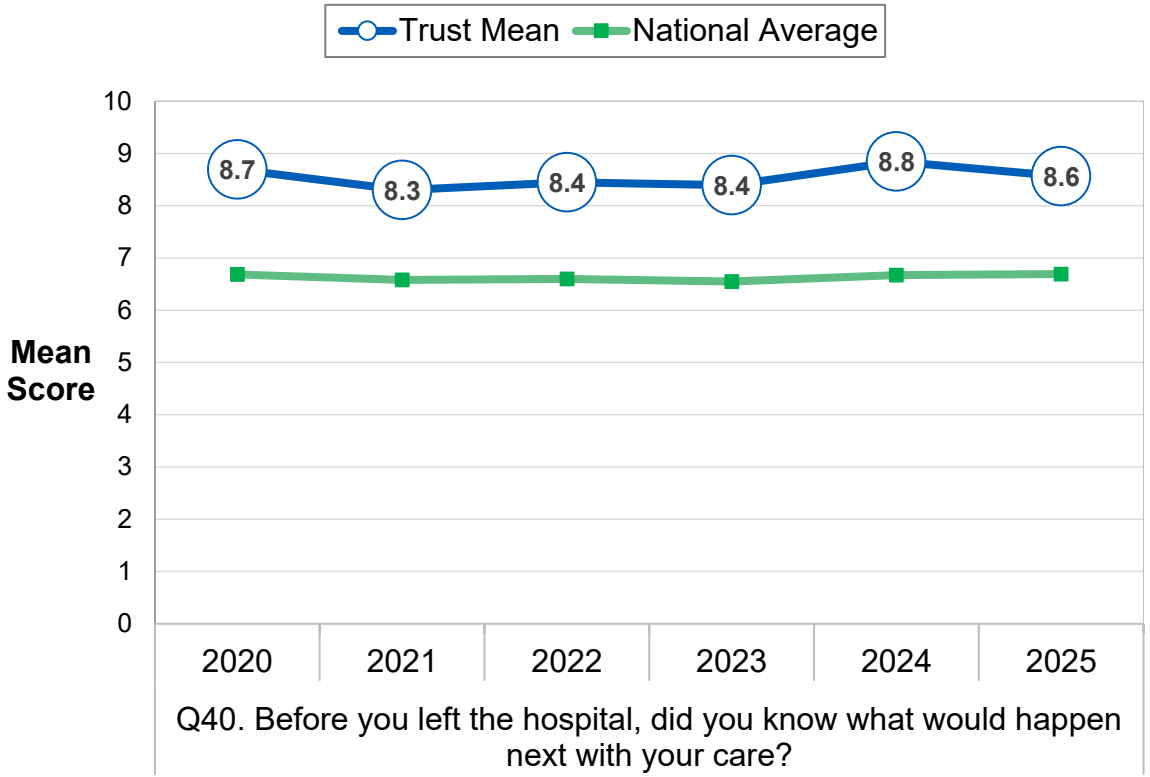
Question scores



Q39. Thinking about any medicine you were to take at home, were you given any of the following?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2020: 360; 2021: 370; 2022: 271; 2023: 278; 2024: 317; 2025: 275



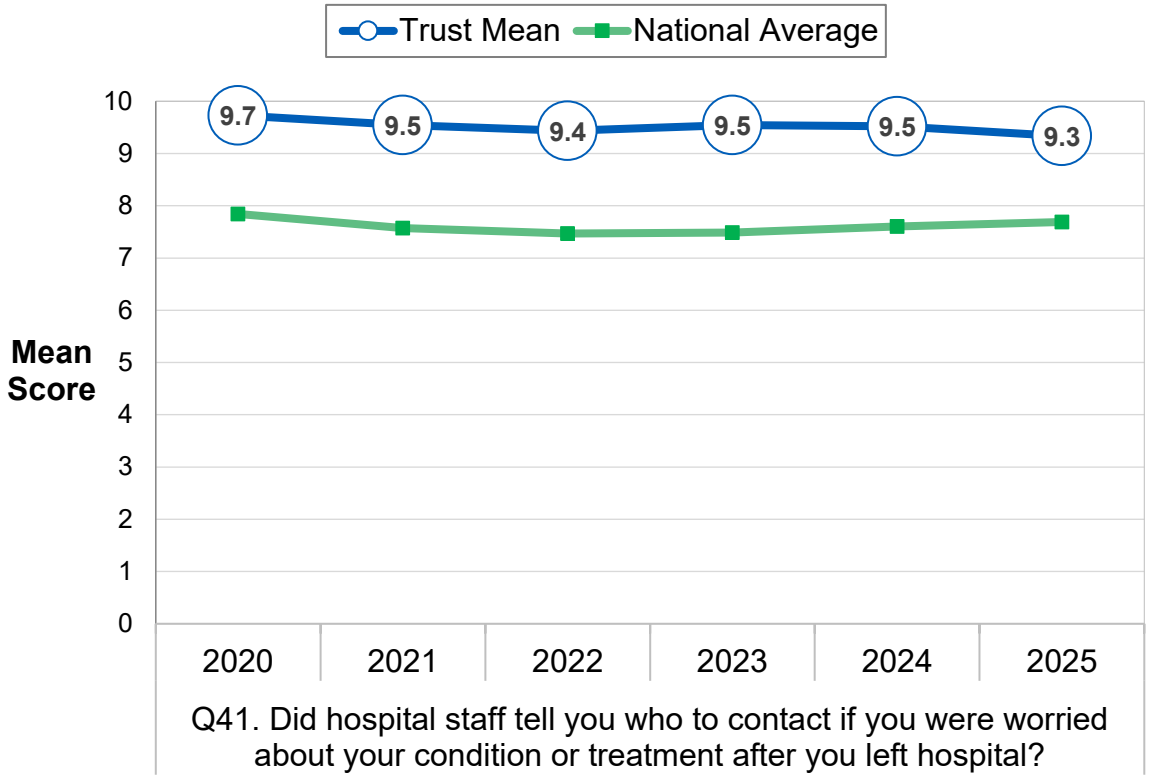
Q40. Before you left the hospital, did you know what would happen next with your care?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated that they did not need further care have been excluded.
Number of respondents: 2020: 586; 2021: 517; 2022: 497; 2023: 483; 2024: 509; 2025: 447

Section 9. Leaving hospital (continued)

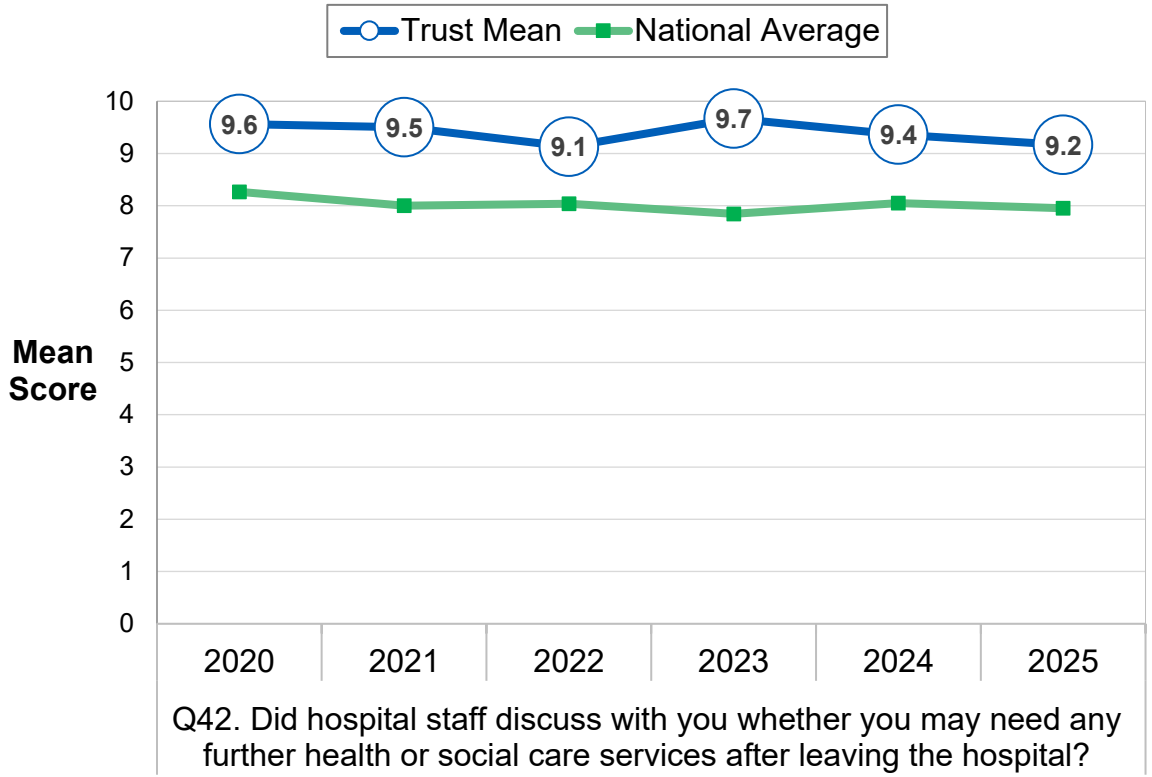
Question scores



Q41. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2020: 600; 2021: 511; 2022: 499; 2023: 486; 2024: 531; 2025: 477



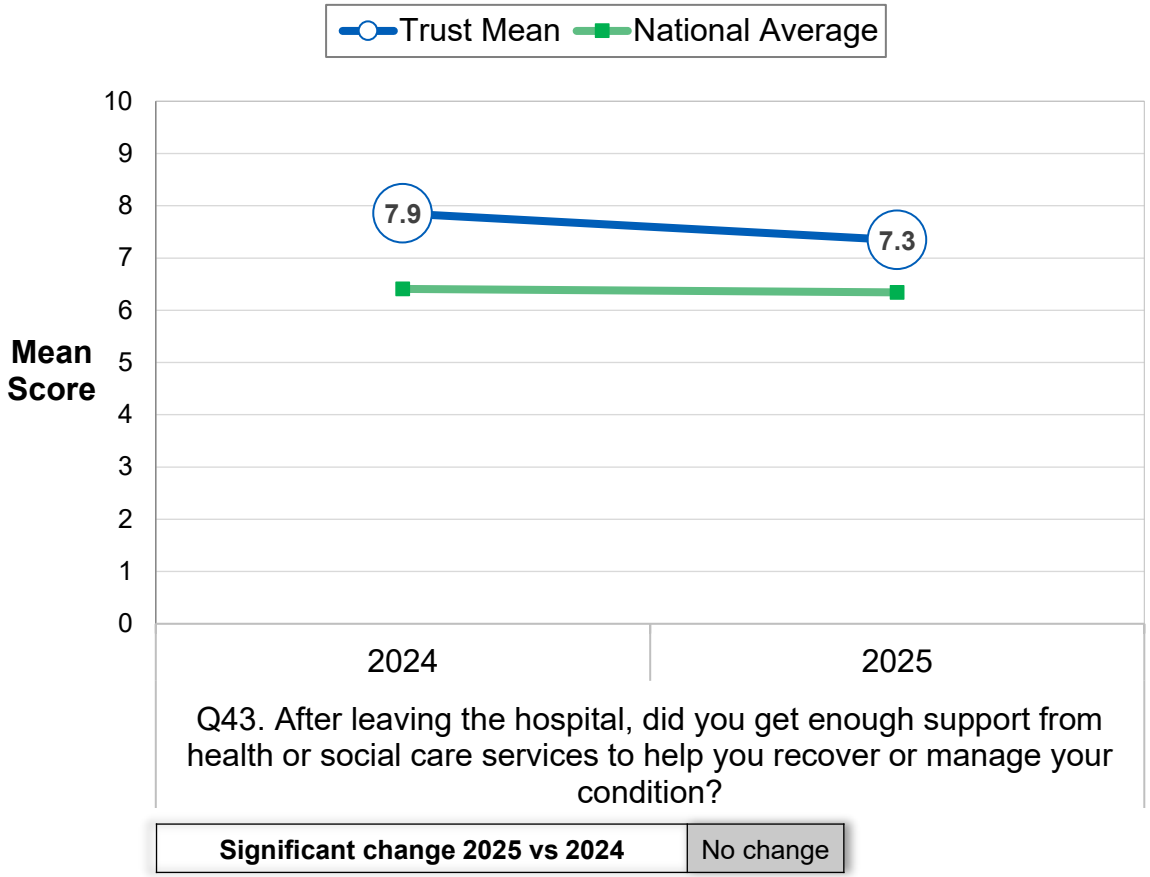
Q42. Did hospital staff discuss with you whether you may need any further health or social care services after leaving the hospital?

Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all. Respondents who stated that it was not necessary to discuss it, or that they didn't know or couldn't remember have been excluded.
Number of respondents: 2020: 257; 2021: 239; 2022: 209; 2023: 178; 2024: 207; 2025: 163

Section 9. Leaving hospital (continued)

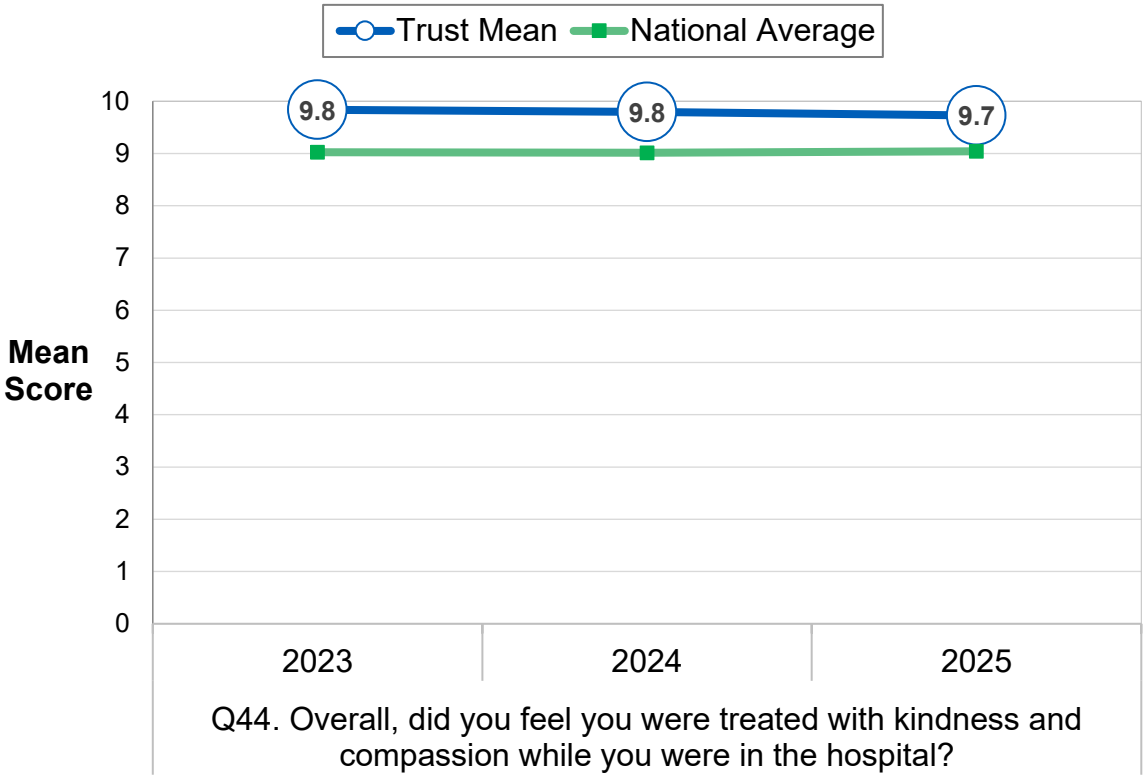
Question scores



Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2024: 237; 2025: 163

Section 10. Kindness and compassion

Question scores

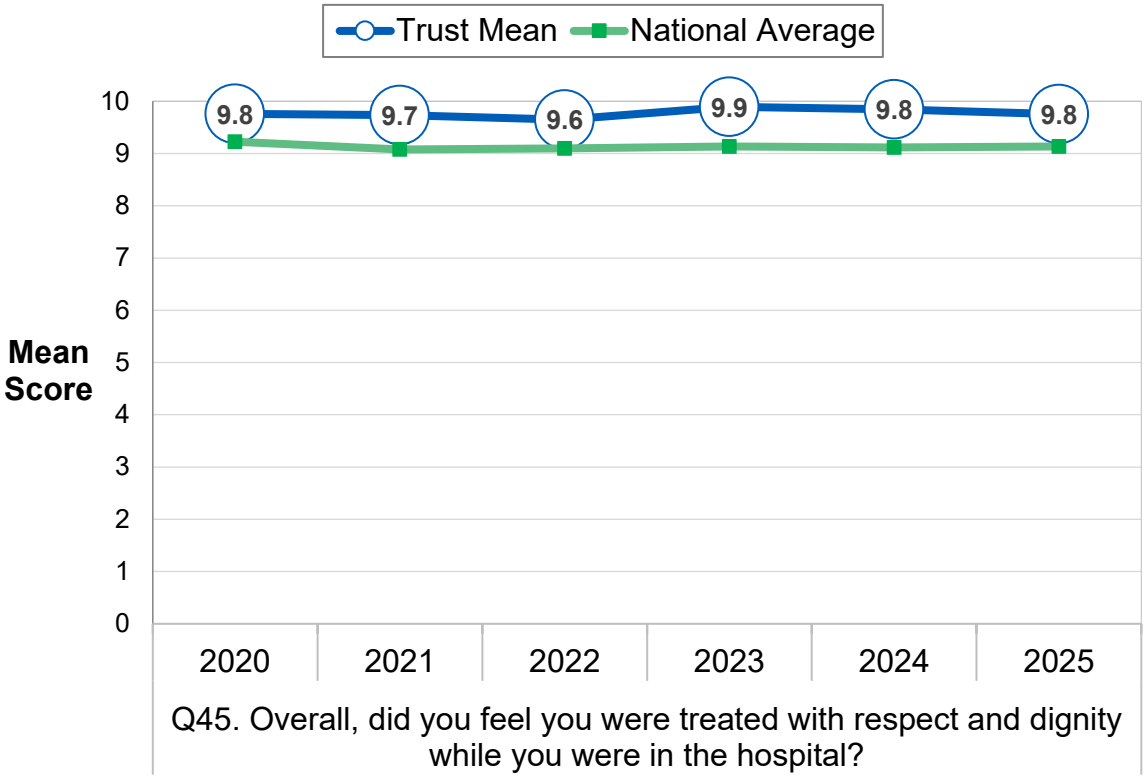


Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2023: 524; 2024: 556; 2025: 493

Section 11. Respect and dignity

Question scores

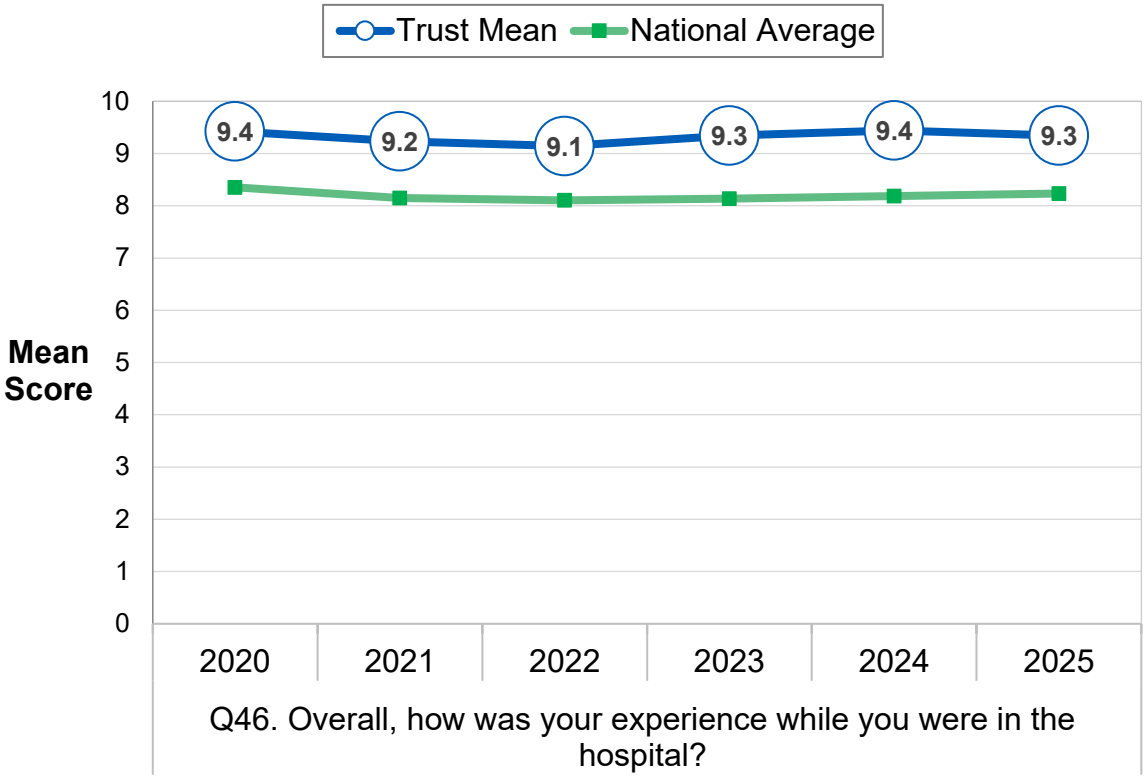


Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2020: 630; 2021: 536; 2022: 534; 2023: 520; 2024: 553; 2025: 491

Section 12. Overall experience

Question scores



Significant change 2025 vs 2024	No change
Significant change 2025 vs 2023	No change

Answered by all.
Number of respondents: 2020: 630; 2021: 536; 2022: 535; 2023: 520; 2024: 558; 2025: 493

Comparison to other trusts

Comparison to other trusts

The questions at which your trust has performed better or much better when compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much better than expected

- Q4. How would you rate the quality of information you were given, while you were on the waiting list to be admitted to hospital?
- Q5. How long do you feel you had to wait to get to a bed on a ward, after you arrived at the hospital?
- Q7_8. Were you ever prevented from sleeping at night by any of the following? I was not prevented from sleeping
- Q8. How clean was the hospital room or ward that you were in?
- Q9. Did you get enough help from staff to wash or keep yourself clean?
- Q10. If you brought medication with you to hospital, were you able to take it when you needed to?
- Q12. Were you able to get hospital food outside of set mealtimes?
- Q14. When you asked doctors questions, did you get answers you could understand?
- Q15. Did you have confidence and trust in the doctors treating you?
- Q17. When you asked nurses questions, did you get answers you could understand?
- Q18. Did you have confidence and trust in the nurses treating you?
- Q19. When nurses spoke about your care in front of you, were you included in the conversation?
- Q20. In your opinion, were there enough nurses on duty to care for you in hospital?
- Q21. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?
- Q22. To what extent did staff looking after you involve you in decisions about your care and treatment?
- Q23. How much information about your condition or treatment was given to you?
- Q24. Did you feel able to talk to members of hospital staff about your worries and fears?
- Q25. Were you given enough privacy when being examined or treated?
- Q26. Do you think the hospital staff did everything they could to help control your pain?
- Q27. Were you able to get a member of staff to help you when you needed attention?
- Q28_6. Thinking about your care and treatment, did hospital staff take into account the following individual needs? Mental health needs (e.g. a quiet space, emotional support)
- Q32. To what extent did hospital staff involve you in decisions about leaving the hospital?
- Q35. Were you given enough notice about when you were going to leave hospital?

Comparison to other trusts

The questions at which your trust has performed better or much better when compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?
- Q7_1. Were you ever prevented from sleeping at night by any of the following? Noise from other patients
- Q7_2. Were you ever prevented from sleeping at night by any of the following? Noise from staff
- Q7_4. Were you ever prevented from sleeping at night by any of the following? Hospital lighting
- Q11. Did you get enough help from staff to eat your meals?
- Q13. During your time in hospital, did you get enough to drink?
- Q16. When doctors spoke about your care in front of you, were you included in the conversation?
- Q33. To what extent did hospital staff involve your family or carers in decisions about you leaving the hospital?
- Q39. Thinking about any medicine you were to take at home, were you given any of the following?
- Q43. After leaving the hospital, did you get enough support from health or social care services to help you recover or manage your condition?

Comparison to other trusts

The questions at which your trust has performed better or much better when compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat better than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions at which your trust has performed better or much better when compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions at which your trust has performed better or much better when compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions at which your trust has performed better or much better when compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- No questions for your trust fall within this banding.

For further information

Please contact the Survey Coordination Centre:
inpatient@surveycoordination.com

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**105-26**		
Report title:	Health & Safety Annual Report FY 2025/26				
Sponsor:	Liz Blackburn, Acting Chief Nursing Officer				
Author:	Jasmin Wagstaff, Health & Safety Governance Facilitator				
Appendices:	None				
Executive summary					
Purpose of report:	The purpose of the report is to provide the Board with a summary of principal activity and outcomes relating to the management of health and safety at work within Queen Victoria Hospital NHS Foundation Trust (QVH) during the financial year 2025/26.				
Summary of key issues	**Key Achievements** • Re-established and strengthened Health & Safety governance and reporting arrangements. • Completion of a Health & Safety gap analysis, with 25 of 38 actions delivered and remaining actions under active oversight. • Continued positive incident reporting culture, supported by enhanced Datix data capture and targeted deep-dive reviews. • Improvements in staff safety and wellbeing support, including Safe Haven provision, post-incident support, and expanded wellbeing initiatives. • Significant progress in policy compliance, reducing overdue Health & Safety related policies to a single outstanding item. • Delivery of Estates safety improvements, establishment of specialist safety groups, and appointment of a new Fire Safety Officer. • Ongoing delivery of mandatory training, with systems in place for monitoring and escalation. **Key Risks and Challenges** Despite these strengths, the report highlights material and interconnected risks that require continued oversight: • Capacity and sustainability pressures in multiple areas, which affect timeliness and completion of Risk assessments and training attendance • Estates and fire safety risks, driven by infrastructure challenges, delayed actions, and outstanding fire incident investigations. • Workforce wellbeing pressures, with sickness absence marginally above target and increasing Occupational Health demand, particularly relating to mental health and musculoskeletal conditions. • A statutory compliance gap relating to the absence of Health Surveillance provision. • Variable compliance in risk assessments, COSHH processes, and mandatory training, particularly among non-permanent staff.				
Recommendation:	The Board is asked to take assurance from the report.				
Action required	Approval	Information	Discussion	**Assurance**	Review
Link to key strategic objectives (KSOs):	**KSO1:**	KSO2:	**KSO3:**	KSO4:	KSO5:
	To deliver outstanding care	*To innovate and improve*	***To be an excellent employer***	*To deliver sustainable services*	*To collaborate with others*
Implications					
Board assurance framework:	KSO1 & KSO3				

Organisational risk register:	Estates and Health & Safety related Risks			
Regulation:	CQC, Health and Safety			
Legal:	Health and Safety at Work etc. Act 1974			
Resources:	None			
Assurance route				
Previously considered by:	Quality and Safety Committee			
	Date:	June 2026	Decision:	Submit to Trust Board
Next steps:				

Queen Victoria Hospital
NHS Foundation Trust

Holtye Rd,
East Grinstead
RH19 3DZ

Quality & Safety

Health & Safety Annual Report

Report covering the period from
April 2025 to March 2026

Document Control: Quality and Safety Committee

Executive sponsor: Liz Blackburn, acting Chief Nursing Officer

Authors: Jasmin Wagstaff, Health & Safety Governance Facilitator

Date: 20/05/2026

Type: Annual Report
Version: 2
Pages: 20
Status: Public. Written and prepared for the Trust Board
Circulation: Quality & safety committee

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1. Executive Summary

This report provides assurance on the Trust's Health & Safety performance for the 2025/26 financial year and demonstrates compliance with statutory duties under the Health & Safety at Work etc. Act (1974). It draws on intelligence from multiple assurance sources, including incident reporting, workforce data, Estates reports, and Occupational Health information.

Overall Assurance

The Trust has maintained safe operations during the year, supported by sound governance arrangements, a positive reporting culture, and committed staff. Health & Safety oversight is embedded within the Trust's governance framework, with clear reporting lines from the Health & Safety Group through to Executive and Board-level committees. Incident reporting has remained stable, with 99.4% of incidents resulting in no or low harm, providing assurance that serious harm remains rare.

Key Achievements

- Re-established and strengthened Health & Safety governance and reporting arrangements.
- Completion of a Health & Safety gap analysis, with 25 of 38 actions delivered and remaining actions under active oversight.
- Continued positive incident reporting culture, supported by enhanced Datix data capture and targeted deep-dive reviews.
- Improvements in staff safety and wellbeing support, including Safe Haven provision, post-incident support, and expanded wellbeing initiatives.
- Significant progress in policy compliance, reducing overdue Health & Safety related policies to a single outstanding item.
- Delivery of Estates safety improvements, establishment of specialist safety groups, and appointment of a new Fire Safety Officer.
- Ongoing delivery of mandatory training, with systems in place for monitoring and escalation.

Key Risks and Challenges

Despite these strengths, the report highlights material and interconnected risks that require continued oversight:

- Capacity and sustainability pressures in multiple areas, which affect timeliness and completion of Risk assessments and training attendance
- Estates and fire safety risks, driven by infrastructure challenges, delayed actions, and outstanding fire incident investigations.
- Workforce wellbeing pressures, with sickness absence marginally above target and increasing Occupational Health demand, particularly relating to mental health and musculoskeletal conditions.
- A statutory compliance gap relating to the absence of Health Surveillance provision.
- Variable compliance in risk assessments, COSHH processes, and mandatory training, particularly among non-permanent staff.

Conclusion

The Trust continues to demonstrate effective Health & Safety governance and a culture of transparency and learning. However, Health & Safety is being delivered within an increasingly pressurised system. Without sustained investment in Estates capacity, workforce wellbeing, and the resilience of compliance arrangements, there is a risk that assurance and performance could potentially deteriorate over time.

2. Introduction

The Queen Victoria Hospital NHS Foundation Trust (QVH) has a duty under the Health & Safety at Work etc. Act (1974), and other subordinate legislation, to ensure, so far as is reasonably practicable, the health, safety and welfare of employees, and those persons who are not employees who might be affected by the activities of the Trust.

In particular, the act requires organisations to provide and maintain:

- A Health and Safety Policy.
- A system to manage and control risks in connection with the use, handling, storage and transport of articles and substances.
- A safe and secure working environment.
- Safe and suitable plant, work equipment and systems of work.
- Information, instruction, training, and supervision as necessary.
- Adequate welfare facilities.
- Consultation with employees on health and safety matters.

There are various arrangements in place to achieve Health & Safety at the Trust. Key stakeholders in the management of Health & Safety at QVH are the Estates and Facilities Department, Human Resources, Occupational Health, Medical Devices, Radiology, Pharmacy, Infection Prevention and Control, the Safety and Patient Experience Team as well as all other departmental managers, link workers and Union Representatives. These teams work collaboratively and meet quarterly to discuss, agree and monitor Health & Safety matters at the Health & Safety Group, which is chaired by the Head of Safety and Patient Experience. The chair reports outcomes of the meeting to the Executive Sub Committee for Quality (ESCQ) and an update from ESCQ is sent to the Executive Committee for Quality and Risk (ECQR) and to the Quality and Safety Committee, a sub- committee of the Board.

This report has been compiled using analysis from the aforementioned teams, incorporating health and safety performance indicators, data, and activity throughout the 2025/26 financial year. It includes information on incidents reported on Datix between 1st April 2025 and 31st March 2026 across the categories of the type: staff safety, estates, infrastructure and environment, visitor/public safety, and security.

3. Service aim, objectives and expected outcomes

The Trust is committed to providing all staff, visitors and service users with a safe environment, in which to be able to work or visit, without suffering any personal injury or ill health. It recognises the need to identify the significant work place hazards on all of its sites/departments and implement any necessary measures, in order to eliminate or reduce the risks of harm, damage or loss.

All employees, and those working on behalf of the Trust, are expected to co-operate with the Trust, and in order that it may comply with any statutory duty placed upon the Trust in terms of Health and Safety legislation. Employees have individual responsibility

	to take all reasonable care for the safety of themselves and others who may be affected by their acts or omissions, and to co-operate with Management in matters of safety.

4. Activity analysis/ achievement

4.1 Health & Safety Governance and Oversight

The Health & Safety Group (HSG) continues to operate as a formal group within the trust's governance structure, providing regular oversight and assurance. Governance processes have been strengthened through the introduction of Alert, Assure and Advise reporting to ECQR.

Regular reports received include:

- Staff safety incidents
- Estates/ Facilities & environmental safety
- General Departmental Risk assessments
- Control of Substances Hazardous to Health (COSHH)
- Moving & Handling
- Workforce wellbeing and sickness absence
- Occupational Health Report
- Departmental and Staff Safety Issues to raise

Reports previously submitted to the Health & Safety Group on Security Management, Violence Prevention and Reduction, and Radiology updates from the Radiation Protection Committee have now been discontinued to avoid duplication, as these are received directly by the relevant Executive sub-committees.

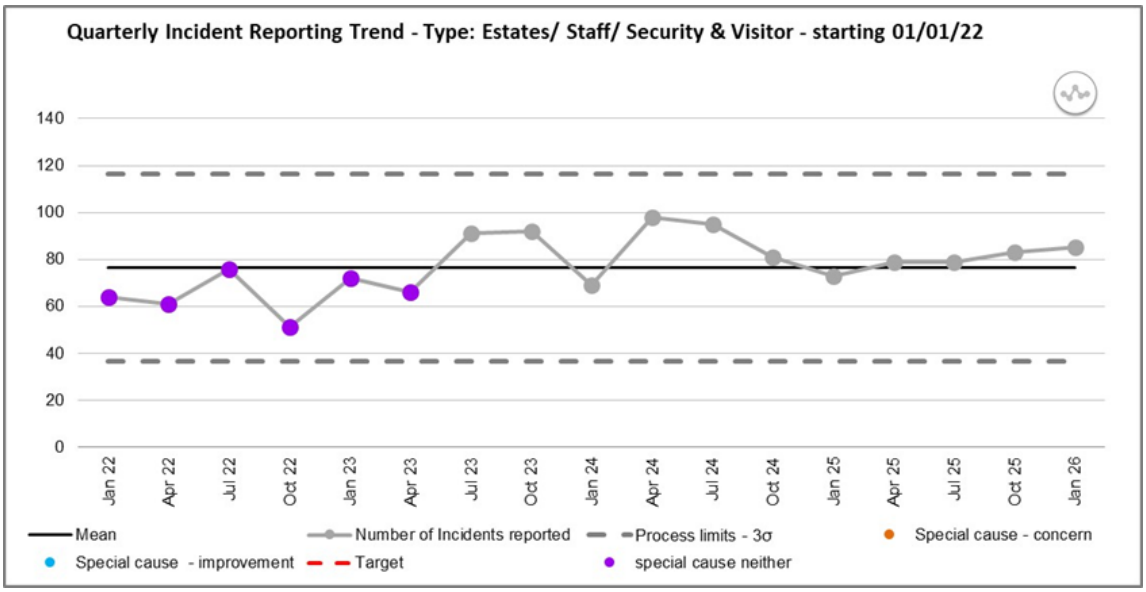
Data is triangulated through Datix, workforce metrics, Estates reports, and Occupational Health data and compliance figures of key H&S areas like COSHH.

Furthermore, following the gap analysis against Health & Safety standards in February 2025, out of 38 resulting actions 66% are completed at the time of reporting with 11 still in progress and 2 actions have not been started. Updates on the action plans are regularly reviewed at ECQR and the Quality & Safety Committee.

4.2 Incident Management and Safety Performance

4.2.1 Incident Overview

Incident numbers have remained stable quarter-on-quarter, with a total of 326 incidents reported in the whole Financial Year 2025/26.
The Statistical Process Control chart below shows common cause variation, indicating no significant deterioration in reporting patterns.



Data extracted from Datix 01/05/2026

Overall, the majority of incidents were graded as near miss, no harm, minor/low harm 99.4% (324). The remaining 0.6% (2) related to moderate harm (1 Estates and 1 Visitor related). The harm levels of incidents showed no change in comparison to 23/24 and 24/25.

4.2.2 Key Incident Themes

The most frequently reported categories across the year were:

- Abuse/ Assault
- Inoculation (Sharps and Splash) Incidents/ Injuries
- Fire
- Security



Data extracted from Datix 01/05/2026

Abuse/ Assault incidents

Abuse/ Assault incidents are monitored by the Violence and Sexual Safety Oversight Group that reports in to the Workforce Executive subcommittee.

Over the year multiple improvements have been undertaken including enhanced Datix data capture for abuse/assault incidents, the introduction of quick QR code incident reporting and the development of post incident support resources. At the time of reporting compliance with the VPR standard sits at 98%.

Inoculation (Sharps/Splash) incidents/ injuries

Inoculation (Sharps/Splash) incidents/ injuries were subject to a detailed review during the year through a dedicated deep dive analysis, undertaken to better understand the factors contributing to the previously observed increase in this incident type.

As a result, further work has been carried out in collaboration with the Theatre Quality and Compliance Lead to enhance the Datix incident reporting form. Additional fields have been introduced to capture more meaningful and case-specific information, enabling more targeted analysis and the development of focused interventions aimed at reducing recurrence. These changes were implemented in March 2026.

In addition, senior clinical staff have been engaged to support and reinforce key safety learning for junior doctors. The following areas were identified as priorities:

- Continued reinforcement of safe sharps handling practices within the theatre environment, particularly during high-activity stages of procedures such as wound closure
- The importance of clear verbal and visual communication when handling, transferring, or repositioning sharps
- Ongoing support for junior doctors to build awareness of theatre workflows, sharps-related risks, and expected safety practices when working in close proximity to operating surgeons

This programme of work remains ongoing.

Other Notable points:

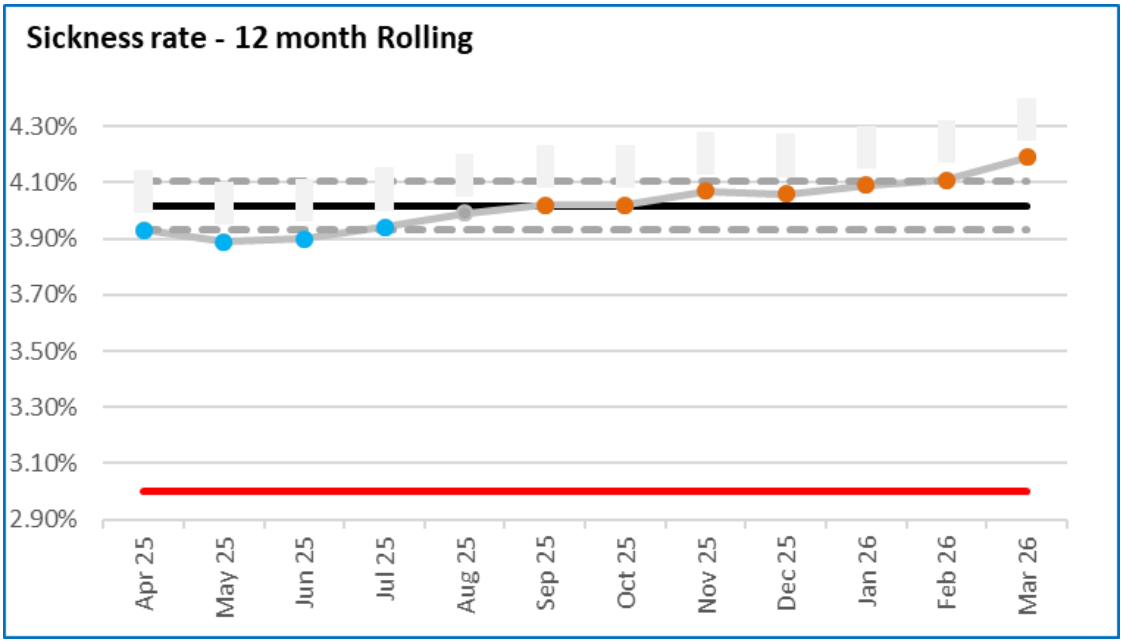
- One RIDDOR-reportable incident (visitor fall) occurred, with contributory factors linked to Estates issues (lift unavailability).
- Estates-related incidents showed special cause variation, highlighting environmental and infrastructure pressures.
- Fire Safety related incidents – almost half (15) of the incident investigations remain outstanding at the time of reporting

Summary: Incident reporting culture remains positive, but learning and investigation follow-through is inconsistent, particularly for Environmental/ Infrastructure and fire-related incidents.

4.3 Workforce Health, Safety and Wellbeing

4.3.1 Sickness Absence

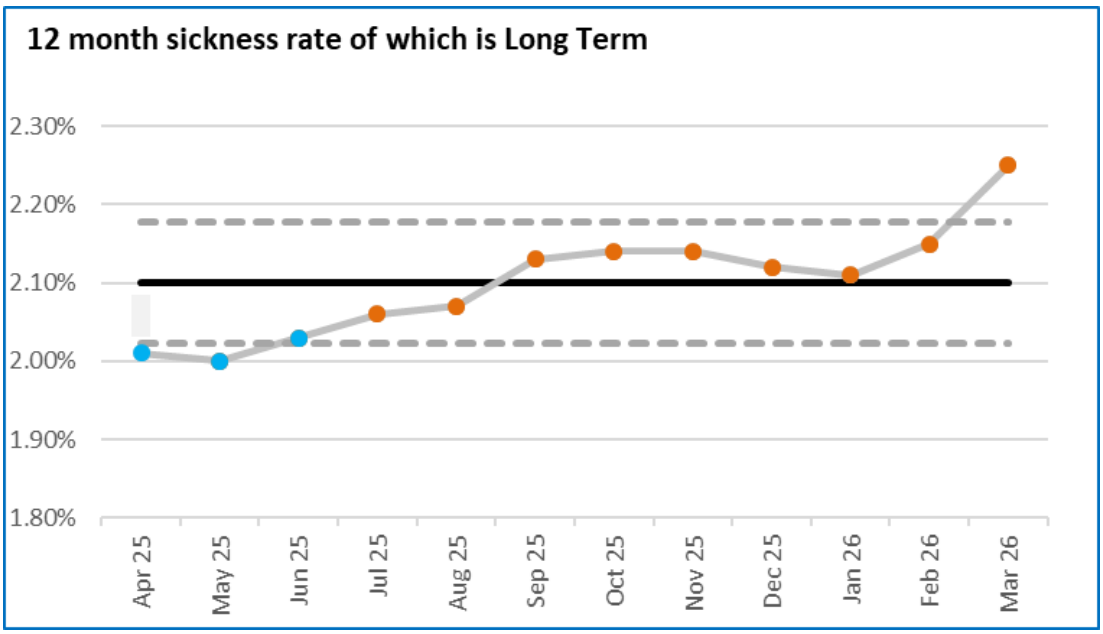
Rolling 12-month sickness absence reached 4.19% in March 2026, marginally above the national system target of 4% and was driven by the ongoing long term sickness absence over the period.



Extracted from Workforce Update Report April 2026

Long-term sickness absence shows an increase and was predominantly driven by:

- Mental health (stress, anxiety, depression)
- Musculoskeletal (MSK) conditions and
- Oncology

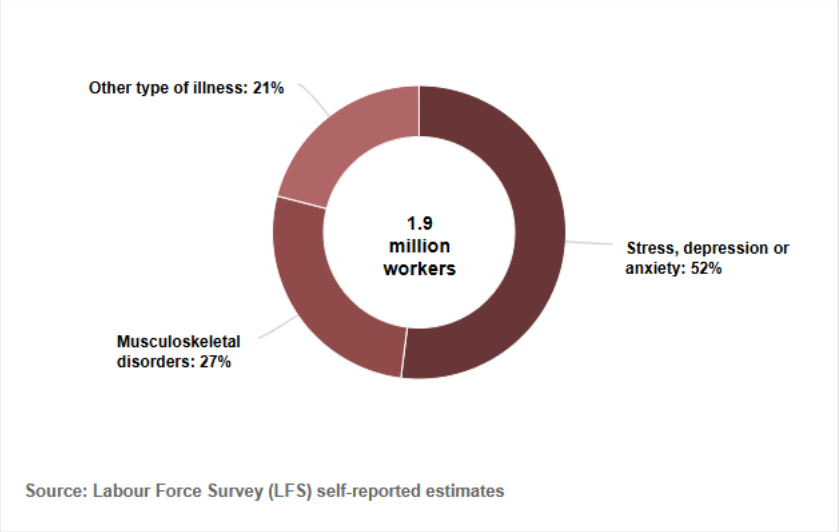


Extracted from Workforce Update Report April 2026

A sickness deep dive has been carried out and an associated action plan has been put in place and is overseen by Workforce. Actions include updates to the Managing Sickness policy to be more supportive and clearer in respect of reasonable adjustments, clearer guidance on Ill Health Retirement processes, planned work for attendance toolkits, and management and employee support hubs as well as a review of investigation and Employee Relations processes to gain insights from a wellbeing perspective.

Furthermore, it is noteworthy that this trend mirrors the key national statistics published by the Health & Safety Executive (HSE) 2025 on work related ill-health, with Stress, depression, or anxiety driving the overall increase in ill health.

New and long-standing cases of work-related ill health by type, 2024/25



Source: Labour Force Survey (LFS) self-reported estimates

QVH continues to have a range of support options available like the Employee Assistance Programme (Vivup), the Stay Well Team, Occupational Health, Stream and the newly introduced Line Manager training, which includes fostering cultures of wellbeing in teams.

4.3.2 Occupational Health

Occupational Health services are provided by Cordell Health. Staff referrals reached the highest quarterly total of the past two years in Quarter 4.

The largest referral groups were:

- Mental health (approx. 42%)
- MSK conditions (approx. 35%)

While service performance remained largely within Key Performance Indicators (KPI), increased demand has extended average case closure times.

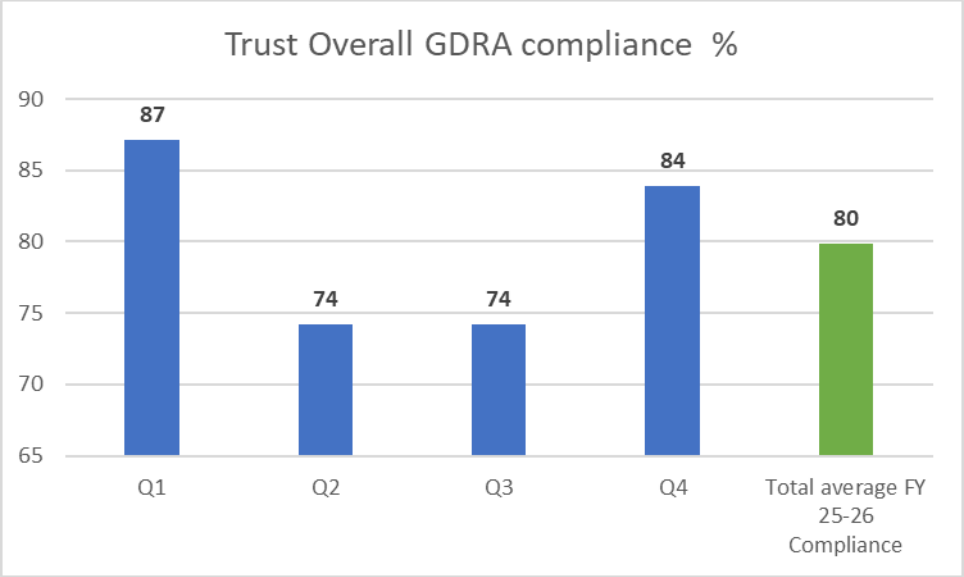
The provision of Health Surveillance through the Occupational Health service still remains outstanding. This is an important obligation for employers under the Health and Safety at Work etc. Act 1974 and specific regulations like COSHH, Noise at Work, and Control of Vibration at Work Regulations and can lead to HSE intervention and potential fines if not undertaken.

4.4 Risk Management and Compliance

4.4.1 General Departmental Risk Assessments (GDRAs)

Most departmental risk assessments are current and reviewed in line with their scheduled timelines. However, a small number have experienced significant delays or remain outstanding, largely due to capacity constraints within teams. These constraints were staff availability as well as an increase in workload due to the introduction of various new digital

systems like the Electronic Patient Record, the new QNET (staff intranet) and the Electronic Staff Record (ESR) - Manager Self Service.



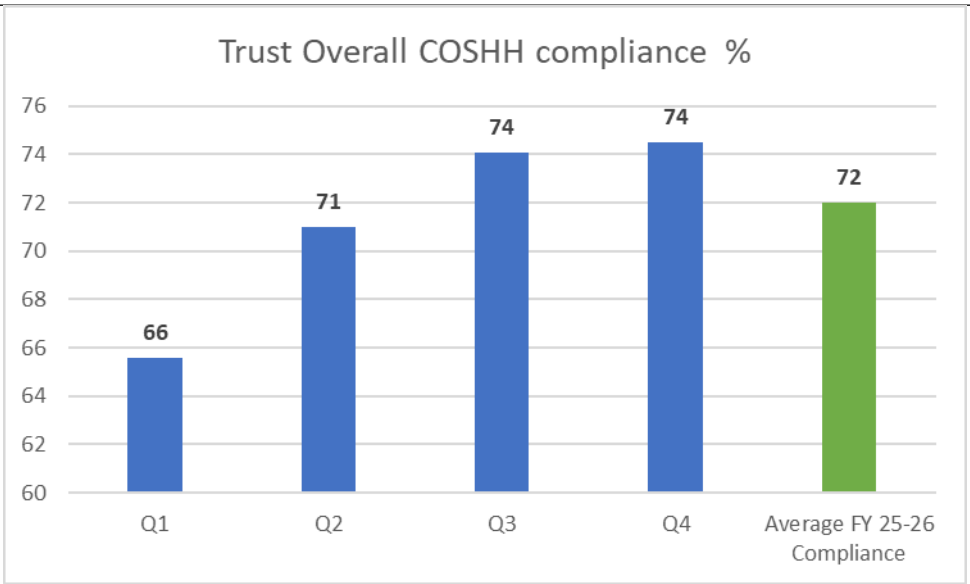
This presents an assurance concern, as these assessments are a statutory requirement and form a key control in identifying and managing environmental and staff-related risks. The team continues to support managers with completing these to achieve full compliance.

4.4.2 Control of Substances Hazardous to Health (COSHH)

All 19 Trust areas that require a COSHH representative have one in place. In addition, three areas (Histopathology, Prosthetics Laboratory and Eye Bank) are subject to national accreditation or standards, providing an additional level of assurance and alignment with recognised good practice.

Furthermore, the trust has filled the vacancy in post through a temporary secondment and targeted COSHH compliance work has commenced over the year.

COSHH compliance data is primarily derived from departmental inventories, sourced from either local COSHH folders or the Trust N-Drive. This information underpins the compliance data presented in the accompanying graph.



During the year, compliance data was not available for some areas in certain quarters. This was largely due to changes in process, which impacted both departmental reporting and the Trust's overall compliance position. Other areas demonstrated variable compliance across the year, similarly influencing the Trust-wide picture.

In one department, the absence of an appointed COSHH representative resulted in no data being available for reporting during the period. This has since been addressed, and improved compliance and reporting are anticipated in the next quarter of the new financial year.

To improve consistency and assurance, departments are required to align electronic and hard-copy records, use Trust-approved templates, and ensure that all COSHH risk assessments are current and supported by up-to-date Safety Data Sheets.

Staff have reported challenges in completing COSHH responsibilities within existing time and resource constraints. The current system, which relies on Word and Excel-based documentation, is administratively intensive. Managers are aware of these pressures and have been reminded of the need to provide protected time for COSHH representatives.

To enhance sustainability, improve consistency and compliance, reduce administrative burden, and strengthen central oversight, the Trust may wish to consider, in collaboration with the new partner trust, the availability of a dedicated COSHH software solution, the potential to share this resource, and the option to convert the temporary secondment post into a permanent position.

4.4.3 Moving and Handling and Display Screen Equipment (DSE) Assessments

Moving and Handling Incidents

The number of Moving and Handling related incidents reported via Datix decreased slightly this Financial year compared to the previous year (from 15 to 14). There have been no RIDDOR reportable incidents with regards to Moving and Handling.

Most incidents involved insufficient staff risk assessment, Infrastructure challenges (doors) and unexpected patient movements during transfers. Unpredictability in patient behaviour remains a recognised and inherent risk associated with Moving and Handling.

Moving and Handling Training

Training compliance for Level 1 (non-clinical e-learning) has met the 90% target, whereas Level 2 (clinical, face-to-face) remains below the required threshold. The Learning & Development (L&D) team continues to monitor attendance closely and regularly promotes available training opportunities. Level 1 training is more accessible due to its e-learning format, while Level 2 remains face-to-face to support its practical components.

Did Not Attend (DNA) rates in 2025 were largely linked to staffing pressures and the transition from annual updates to biennial training, in line with national NHS guidance. To improve attendance and reduce DNA rates, training group sizes have been increased, and sessions (including refresher and induction training) are now delivered monthly. The L&D team also provides proactive reminders to managers and staff regarding upcoming sessions. In addition, bespoke training continues to be delivered in high-risk areas.

Display Screen Equipment (DSE)

A Display Screen Equipment User (DSE user) is a worker who uses DSE for continuous or near-continuous spells of an hour or more as part of their normal working day.

It is the responsibility of the staff member to complete the DSE Self-Assessment form in collaboration with their line manager. Any issues or adjustments are escalated to and reviewed by the Moving and Handling Advisor for recommended actions.

Numbers of DSE assessments reviewed by MH advisor was 48 in FY 2024/25 and 42 in 2025/26.

A more robust and centralised method for tracking DSE assessments is needed and is identified as a key area for future improvement.

Workstations on Wheels (WoW) guidance

Workstations on Wheels (WoWs) were introduced in November 2025 as part of the Archie Electronic Patient Record programme. Following implementation, a number of incident reports and formal escalations were received relating to musculoskeletal (MSK) concerns associated with their use.

A DSE assessment is not considered applicable to this equipment, as WoWs are not fixed workstations and are designed for short-duration or intermittent use only. As such, risks are more appropriately managed through the application of general ergonomic principles. To support this, a guidance document on the safe use of WoWs was developed collaboratively by Moving and Handling, Health & Safety, Infection Prevention and Control, and Estates.

4.4.4 Policies

Twelve Health & Safety related policies within the Estates remit remained overdue or delayed over the year.

There has been extensive work undertaken to improve the number of policies in date. The number of out of date Health & Safety related policies has reduced to only one at the point of reporting.

Summary: Risk management and compliance arrangements are largely effective and improving, with demonstrable progress in policy compliance; however, residual risks remain in relation to overdue assessments, COSHH sustainability and administrative capacity.

4.5 Estates, Facilities and Environment

Health and safety is directly influenced by Estates through the condition, design, and management of buildings and infrastructure, as these elements shape the safety of the healthcare environment.

Estates related factors represented a significant contributor to Health & Safety risk during the year, reflecting broader system pressures rather than isolated issues.

Key themes identified include:

- Delays in progressing actions relating to:
  - Fire safety matters
  - Maintenance and defect resolution
  - Lighting, access and wider environmental risks
- Recurring equipment issues, including lifts, doors and alarm systems
- Capacity and workforce challenges within Estates, impacting responsiveness and delivery
- Variable attendance and reporting to governance forums, which has affected the timeliness of assurance and oversight

The teams continue to work collaboratively to ensure hazards are identified, managed, and continuously improved.

Progress made during the Financial Year:

- Multiple Estates related improvements/ upgrades including:
  - Fire alarm upgrade works completed
  - Asbestos removal progressing
  - Water, Ventilation, Electrical and Fire Safety Groups established and monitoring in place
  - Appointment of a new Waste Manager and Fire Safety Officer
  - Provision of additional staff parking spaces
  - Introduction of the Premises Assurance Model (PAM) platform - Concerto

Summary: Estates risks are clearly captured on the risk register and monitored through established oversight arrangements. Capacity limitations remain a challenge, reinforcing the need for robust prioritisation of Estates work.

4.6 Training and Competence

The table shows compliance with the mandatory elements of Health and Safety at work as at 31 March 2026.

Training Name	Compliance Permanent Staff	Compliance Non-Permanent Staff	Compliance All Staff
Fire Evacuation	85.53%	53.16%	81.17%
Fire Safety Awareness	93.13%	81.58%	91.58%
Conflict Resolution	86.30%	81.77%	85.54%
Health, Safety & Welfare	93.79%	87.89%	92.99%
Infection Prevention & Control Level 1	90.46%	90.24%	90.44%
Infection Prevention & Control Level 2	86.52%	73.33%	84.35%
Moving & Handling Level 1	90.64%	85.56%	90.07%
Moving & Handling Level 2	85.55%	78.22%	84.34%
Fit Testing	72.17%	38.35%	65.61%

These training courses are delivered by the different leads via face to face training or via e-learning. The numbers show clearly that non-permanent staff require a follow up. Managers are sent an automatic email from ESR (Electronic Staff Record) about the training compliance rates of each member of staff they line manage and these should also be reviewed during the annual appraisal process.

All of these compliance rates are now reported regularly at relevant governance meetings for monitoring purposes.

The Infection Control Team co-ordinate the fit testing programme for clinical staff to ensure safe practice is delivered. Compliance with fit testing has improved over the year, however remains below target in the trust. A Portcount machine simplifies testing and will be rolled out in the next financial year.

The Fire Safety Officer will focus on the fire evacuation programme of training.

Summary: Training systems are in place, but compliance sustainability is a risk, particularly with the non-permanent staff group.

5. Involvement & Engagement

5.1 Health & Safety Executive (HSE)

The trust has been contacted by the Health & Safety Executive (HSE) three times in the Financial Year 2025/26 due to concerns that have been raised directly with them. This is an increase from last year where we received none. These related to:

- 28/07/2025: Welfare provision in Main Outpatient Department
- 06/08/2025: Gas Safety
- 06/10/2025: ongoing pest control, affecting those on site including employees

All concerns raised were responded to and the cases have subsequently been closed.

5.2 Healthcare Risk Management Group (HRMG)

The Health & Safety Governance Facilitator continues to participate in a regional Health & Safety group; membership includes a variety of acute and community trusts: a valuable source of sharing health and safety at work issues, exploring / seeking solutions and peer support. As an example the newly developed WoW guidance has been shared with other trusts for system improvements.

5.3 Training Delivery

The team continue to deliver the following training:

- Induction and mandatory training
- COSHH
- Volunteer H&S training
- H&S training for managers
- Bespoke training

The Team have reviewed and refreshed all the training slides for the various courses and continue to receive very positive feedback on these sessions.

The team further provide Datix training on an ad hoc, one-to-one basis to all members of staff requiring it.

5.4 Environmental Audits

The Health & Safety Governance Facilitator attends monthly environmental audits undertaken collaboratively with the Infection Prevention and Control Team, Estates and Facilities colleagues, and Heads of Nursing. These audits aim to systematically review and enhance QVH's environmental performance while ensuring compliance with relevant regulatory requirements.

The audits support the identification of areas for improvement, enable progress to be monitored against sustainability objectives, and promote a responsible approach to environmental management. Action plans arising from the audits are developed and monitored, and they also support organisational preparedness for the formal annual Patient-Led Assessments of the Care Environment (PLACE) programme.

5.5 Internal group meetings

The team is actively involved in and provides regular input to the following health and safety related meetings:

- Executive Sub Committee for Quality
- Executive Sub Committee for Estates and Facilities
- Health & Safety Group
- Violence and Sexual Safety Oversight Group

	➢ Infection Prevention and Control Meeting ➢ Medical and Clinical Devices Group Meeting ➢ Ventilation Safety Group ➢ Fire Safety Group ➢ Electrical Safety Group ➢ Water Safety Group ➢ Estates, Facilities, H&S and Nursing monthly meeting ➢ Radiation Protection Committee ➢ Medicines Management and Optimisation Group incl. Medical Gas Safety In addition to the above, support is given to individual departments.

	6. Learning and continuous improvement
	During the reporting year, the Trust has delivered several important H&S improvements: **Reporting and Safety Culture** • Introduction of quick QR code incident reporting for Abuse incidents • Enhanced Datix data capture for abuse/assault and inoculation incidents/ injuries **Staff Support** • Launch of a Safe Haven support line (extension 4999) for staff experiencing verbal abuse via phone • Post-incident support resources developed for abuse/ assault incidents • Expanded wellbeing initiatives (menopause awareness, neurodiversity, manager training) • Introduction of H&S pages in Staff Intranet (QNET) so staff have access to relevant information, templates and relevant reports for learning in one dedicated area. **Risk Control and Guidance** • Development and approval of Workstation on Wheels (WoW) safety guidance • Improvements in COSHH support and training • Continued delivery of Moving & Handling risk assessments and advice • Various articles in Connect, the Staff Newsletter, to highlight emerging or seasonal risks and give associated advice • The team has added the review and analysis of HSE and CQC health and safety prosecutions relating to human healthcare activities to the Health & Safety Group work plan. Every six months, this information is presented to the group to highlight failures at other organisations, consider whether similar risks could exist at QVH, assess compliance, and identify any required actions.

	7. Recommendations
	Based on the findings of this report, including Datix Incident data, workforce metrics, Estates reports, Occupational Health data and compliance figures of key H&S areas

	like COSHH, several key recommendations have been identified to guide further improvement in the coming year. • Maintain the Health & Safety Group as a key assurance forum, with continued use of Alert, Assure and Advise reporting to ECQR • Strengthen consistency and timeliness of incident investigations, where outstanding actions remain. • Continue oversight and robust, risk-based prioritisation of Estates work to mitigate the impact of ongoing capacity constraints. • Add the lack of provision of Health Surveillance to the corporate risk register and support the implementation of this service to meet statutory requirements and reduce the risk of HSE enforcement. • Ensure managers are supported with statutory risk assessment obligations. • Explore software solution for COSHH, DSE and general Risk Assessment tracking and oversight, potentially shared with the partner trust • Strengthen focus on training compliance particularly for non-permanent staff • Continue initiatives to improve Fit testing, Moving & Handling and Fire Evacuation training compliance • Continue to work collaboratively with all relevant teams to achieve effective Health & Safety management

	8. Future plans and targets
	The team will continue to work with leads to complete the final actions resulting from the assessment against the Workplace Health and Safety Standards. Further work is required to improve departmental compliance with the completion of the General Departmental Risk Assessments and COSHH Risk Assessments, as well as the population of the COSHH Database. This will continued to be monitored at Health & Safety Group. The team has proposed a set of Key Performance Indicators (KPIs) within the draft Health & Safety strategy to further strengthen evaluation of the effectiveness of existing controls, with the intention of implementing these over the coming year.

	9. Conclusions and assurance
	This report provides good assurance that the Trust has effective Health & Safety arrangements in place and is meeting its statutory duties. Strong governance, clear oversight, and a positive reporting culture support safe day-to-day operations, with 99.4% of incidents resulting in no or low harm. There has been clear progress across the year, particularly in strengthening governance, improving policy compliance, enhancing staff support, and delivering Estates safety improvements. These demonstrate a proactive approach to continuous improvement.

	While some risks remain—particularly around capacity, Estates pressures, training compliance, and Health Surveillance provision—the Trust has appropriate oversight and action plans in place to manage these. Overall, the Trust is in a strong position, with a solid foundation to further enhance Health & Safety performance and sustainability in the coming year.

	10. Appendices
	Appendix 1: Snapshot of Health & Safety Qnet pages

	11. Report approval and governance
	This report will be presented to the Executive Committee for Quality & Risk for approval, before being forwarded to the Quality and Safety Committee.

Appendix 1: Snapshot of Health & Safety Qnet pages



Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**106-26**		
Report title:	Learning From Deaths Report – Quarter 2 26/27				
Sponsor:	Tamara Everington, Managing Director / Chief Medical Officer				
Author:	Michelle Wickens Head of Quality and Compliance Karen Carter-Woods, Head of Safety and Patient Experience				
Executive summary					
Purpose of report:	To provide oversight of patient deaths in hospital and within 30 days of an inpatient or outpatient procedure at Queen Victoria Hospital.				
Summary of key issues	• There were 13 deaths within 30 days of hospital procedures • Two patients died whilst inpatients; these deaths were not preventable, and the patients were managed on end-of-life care plans • Eleven patients died outside of QVH but within 30 days of a procedure at QVH; this number is lower than patterns from previous years and no care concerns have been identified on review • No Structured Judgement Reviews were performed • There were 2 Coroner enquiries in this period relating to patients who had had care with the Trust outside the 30-day timeframe; responses have been accepted by the Coroner • No themes, trends, or system-wide learning requiring additional action by the Trust were identified during this period				
Recommendation:	The Board is asked to **note** the report.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	KSO3:	KSO4:	KSO5:
	To deliver outstanding care	*To innovate and improve*	*To be an excellent employer*	*To deliver sustainable services*	*To collaborate with others*
Implications					
Board assurance framework:	None				
Organisational risk register:	None				
Regulation:	Learning from deaths in the NHS				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	Quality and Safety Committee (ELT 26/10 Approved)				
	Date	03/11/26	Decision	Approved	
Next steps:	Trust Board 12th November 2026				

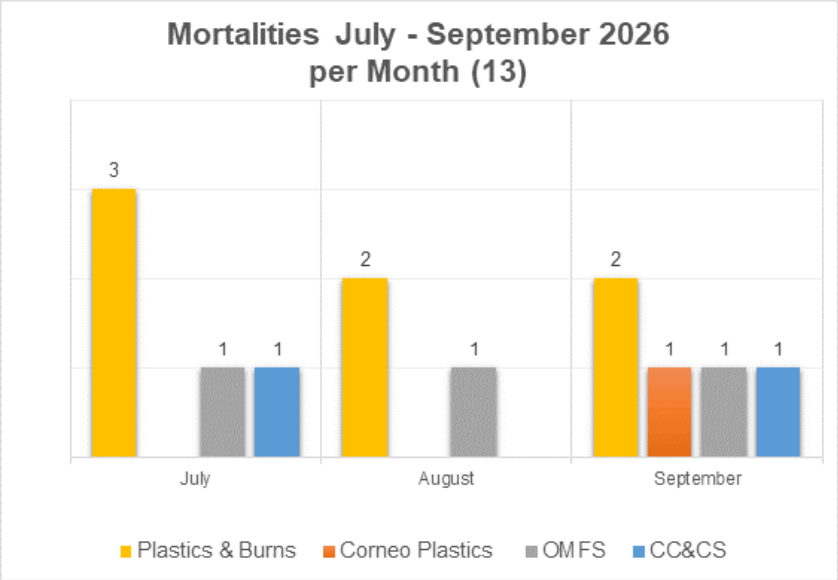
Learning from Deaths Report – Quarter 2

Executive Summary

There has been consistent and appropriate review of deaths within 30 days of a procedure at the Trust throughout this quarter, and no care concerns have been identified:

- There were 13 deaths within 30 days of hospital procedures
- Two patients died whilst inpatients; these deaths were not preventable, and the patients were managed on end-of-life care plans
- Eleven patients died outside of QVH but within 30 days of a procedure at QVH; this number is lower than patterns from previous years and no care concerns have been identified on review
- No Structured Judgement Reviews were performed
- There were 2 Coroner enquiries in this period relating to patients who had had care with the Trust outside the 30-day timeframe; responses have been accepted by the Coroner
- No themes, trends, or system-wide learning requiring additional action by the Trust were identified during this period

Deaths of patients who had been an inpatient or had an outpatient procedure at QVH in the 30 days prior to death by Directorate:



In Quarter 2 the Trust received 13 death notifications of patients who had been an inpatient or had an outpatient procedure at QVH. This is an increase from 6 in Quarter 1. The numbers are lower than the average from last year (27 over quarter 1 and 2 last year). There were two contacts from Coroners in this reporting period, and the Trust has submitted information as requested.

Structured Judgement Reviews (SJRs)

There were no SJRs completed for this period as there were no unexpected deaths either in inpatients or following transfer out.

Mortality Indicators

Medical Examiner (ME) Scrutiny – there was one contact for this period, and information was provided as requested. No further contact in respect of this request.

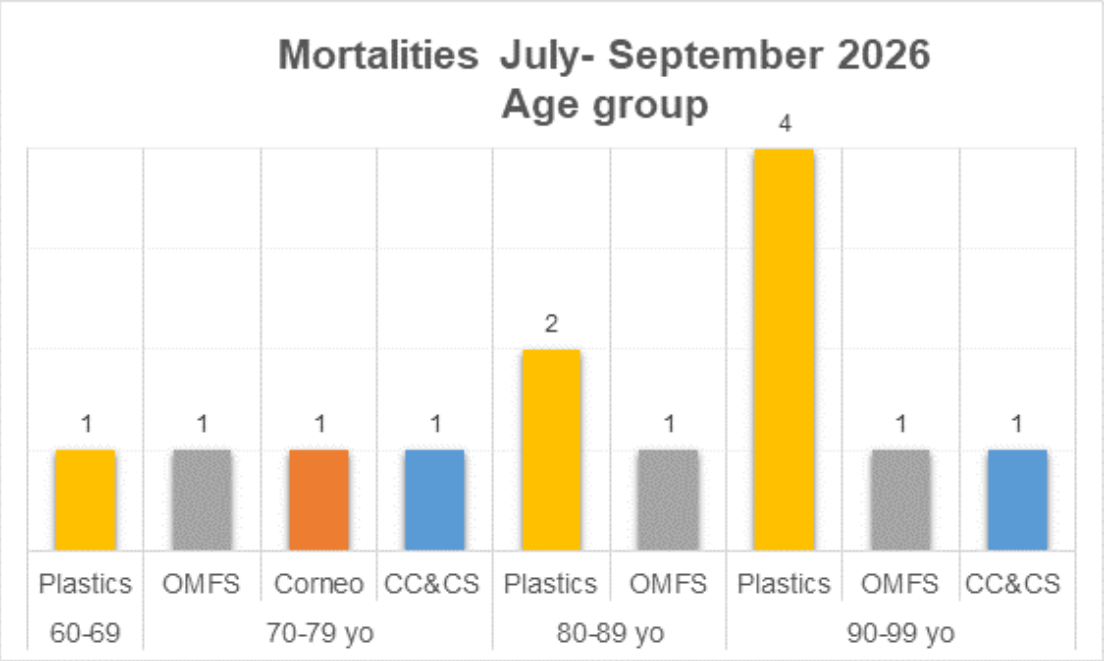
Inquests
One Read Only inquest was held in this quarter for an outpatient who received treatment for a skin lesion. The coroner's conclusion was *'death from a recognised but extremely rare reaction to treatment for skin cancer*'.

System-Wide learning (actions required from other Trusts)
Learning from other Trusts following a death involving any aspect of QVH care would be communicated via the Patient Safety Team. Nothing was recorded in this reporting period.

Any relevant identified learning for QVH patients is included within the Patient Safety Overview reports to the Executive subcommittee for Quality and the Quality and Safety Committee.

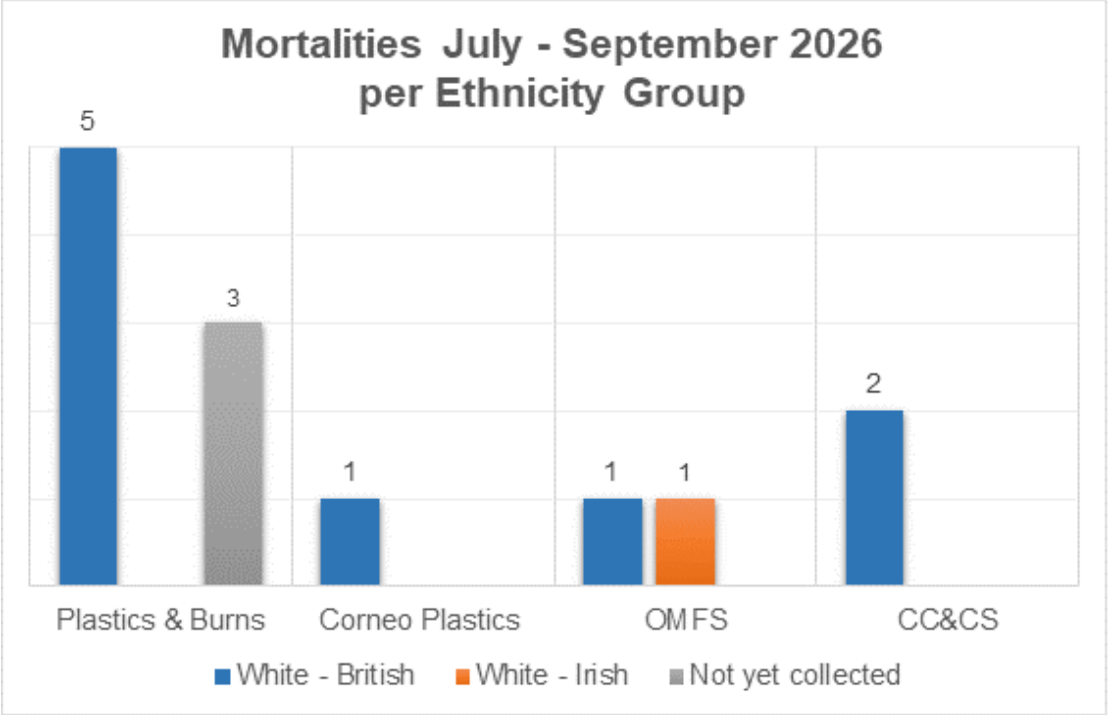
The previously newly convened 'Learning from Death Quality Improvement Network' chaired by the ICB Quality and Learning Senior Manager, remains paused since NHS Sussex formally merged with NHS Surrey Heartlands on the 1 April 2026.

Demographic information in relation to deaths (analysis of deaths by patient demographics to identify any disproportionate impacts).
There is ongoing development of data collection in this area with the aim of identifying any disproportionate impact on subgroups of patients. To date no unexpected impacts have been identified in evaluation by patient age or ethnicity.



The death within the 60-69 age range was due to metastatic disease. All deaths are reviewed by the Trust Chief Medical Officer and Clinical Leads to ensure oversight of opportunities for learning. Ethnicity recording within the Trust continues to be prioritised through the digital transformation projects including the new Patient Administration System due in Spring 2027.

Ethnicity



Recommendation

The Board is asked to **note** the report.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**107-26**		
Report title:	Flu Vaccination Plan 2026/27				
Sponsor:	Liz Blackburn, Acting Chief nursing Officer				
Author:	Rosie Lindley, Head of Nursing				
Appendices:	Appendix 1 - Flu campaign communications example				
Executive summary					
Purpose of report:	To set out the 2026/27 Flu vaccination plan for QVH.				
Summary of key issues	Seasonal influenza remains a significant risk to both patients and healthcare services during the winter period. Vaccination is the most effective way to reduce serious illness, protect vulnerable individuals and minimise disruption caused by staff absence. The QVH Flu Vaccination Programme 2026/27 aims to maximise uptake among eligible staff by providing convenient and accessible vaccination opportunities through Occupational Health clinics, roaming vaccinators and targeted communications. Building on lessons from previous campaigns, the Trust will focus on improving uptake in lower-performing areas, strengthening engagement with managers and enhancing real-time monitoring through the national Record a Vaccination (RAV) system. The programme is supported by a dedicated Flu Vaccination Task and Finish Group, with NHS England setting a minimum threshold of 60% vaccination coverage amongst all eligible frontline healthcare workers. Progress will be monitored weekly, with regular reporting to the Executive Leadership Team and the Executive Sub-Committee for Quality to ensure delivery of a safe and effective campaign.				
Recommendation:	The Board are asked to note the programme for vaccination to staff at the QVH.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1: *To deliver outstanding care*	KSO2: *To innovate and improve*	KSO3: *To be an excellent employer*	KSO4: *To deliver sustainable services*	KSO5: *To collaborate with others*
Implications					
Board assurance framework:	KSO1				
Organisational risk register:	None				
Regulation:	CQC, NHS England				
Legal:	None				
Resources:	UKHSA - Event: Influenza activity in England: implications for clinical practice and laboratory referral – 2 November 2026				
Assurance route					
Previously considered by:	Quality & safety committee				
	Date:	03/11/2026	Decision:	Submit to Board	
Next steps:					

Flu Vaccination Plan 2026/27

Introduction

Seasonal influenza remains a significant cause of illness, hospital admissions and workforce absence during the winter period. Vaccination is the most effective intervention to reduce serious illness from flu and to minimise transmission within healthcare settings.

The national flu vaccination programme aims to:

- Protect those most vulnerable to complications from influenza.
- Reduce transmission of influenza within communities and healthcare settings.
- Maintain NHS service capacity during winter pressures.
- Reduce staff sickness absence and minimise disruption to patient care.

During 2025/26 the Trust achieved a vaccination uptake of 52% to our staff. This was an increase of 5% from the previous year.

Executive summary

NHS England published its letter to all organisations outlining the 'National flu immunisation programme 2026 to 2027'. From 1 October, all frontline healthcare workers, including clinical and non-clinical staff with patient contact, should be offered the seasonal influenza vaccination as a key component of the Trust's infection prevention and control strategy. Employers are expected to ensure the vaccine is readily accessible, actively promote uptake among eligible staff, and monitor the effectiveness and delivery of the vaccination programme.

For QVH, the key focus is ensuring that all eligible staff can access the flu vaccination easily and conveniently to protect themselves, colleagues and patients against flu. Eligible staff include medical, nursing, AHP, Health care scientists, administrative, bank and volunteers. We are unable to offer vaccinations to contractors, agency staff or those undertaking work experience in the Trust as these are not covered by our patient group directive (PGD).

Background

The flu campaign from 2025/26 achieved an uptake of 52% which exceeded our target of 48%. QVH continues to build upon learning from previous vaccination campaigns and recognise that Occupational Health clinics achieved the highest vaccination uptake, roaming vaccinators increased accessibility for clinical teams who were unable to attend scheduled clinics, regular communications maintained staff awareness throughout the campaign and incentives and visible leadership positively influenced participation.

Assessment

A Flu Vaccination Task and Finish Group was established in June 2026 to oversee delivery of the campaign. Vaccines were available on site in preparation for 01 October 2026 and are stored in pharmacy and occupational health. Our Patient Group Direction (PGD) has been reviewed and approved with 12 vaccinators in place. Scheduled Occupational Health vaccination clinics are available weekly and communicated through our weekly internal newsletter.

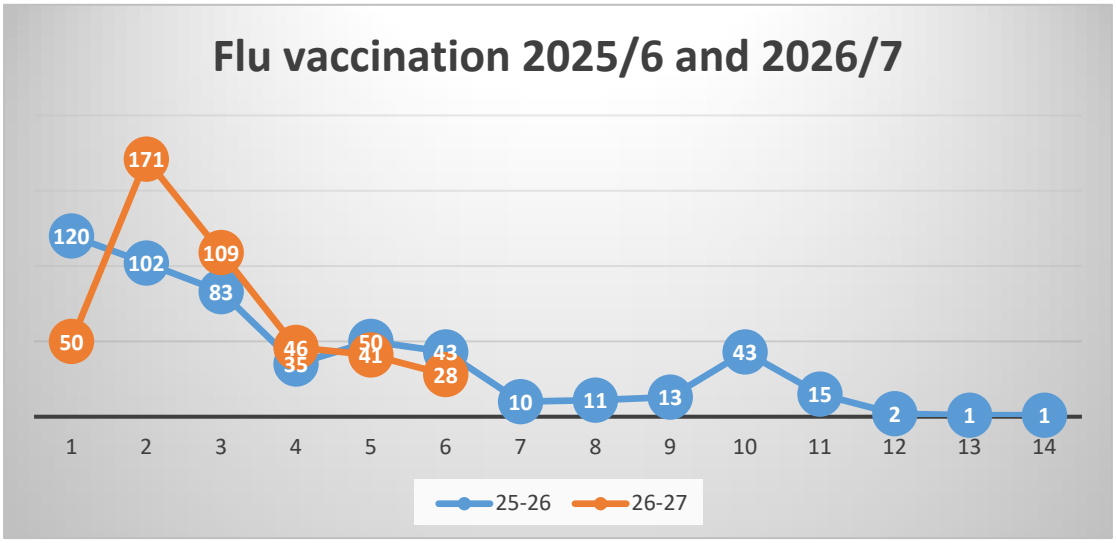
QVH has a target to vaccinate 60% of our eligible workforce in line with uptake targets set by NHS England, we recognise that some of our support staff such as administrative, estates and facilities staff may not be flagged as frontline healthcare

workers (on FDP) despite having patient facing roles and this data will be captured within our internal figures.

A Trust-wide communication launch took place in late September and early October, with weekly campaign updates available in Connect (Appendix One).
Myth-busting and educational materials are available on the Trust intranet and further promotion is via Team Talk, Trust screensavers and staff meetings.

The real time recording and monitoring of vaccination activity can be directly onto the Record A Vaccine national reporting site (RAVs) and we will continue to utilise opt-out forms to improve understanding of reasons for vaccine declination. The Federated Data Platform (FDP) collates all vaccinations from multiple vaccine delivery platforms, allowing data to be reported for all staff who have received the vaccine anywhere in the UK.

Progress so far shows an overall increase in uptake as compared to 25/26 internally.



All flu vaccination delivered on by the Trust programme.

Influenza activity has emerged earlier than usual in the 2026/27 season, with increasing community transmission, emergency department attendances, hospitalisations, ICU admissions and outbreaks. Surveillance indicates predominance of a drifted Influenza A(H1N1)pdm09 strain, however vaccination remains the most effective protection against severe illness. The UKHSA has continued to recommend prompt vaccination for all eligible groups. At the time of writing, over 500 vaccines have been delivered with an overall Trust uptake of 38.9%.

To support the successful delivery of the flu vaccination programme, vaccination uptake will be monitored and performance data will be reviewed regularly to identify areas with lower uptake rates, enabling timely and targeted interventions to improve participation and maximise vaccine coverage across the Trust. The Trust will report flu vaccination activity and uptake in accordance with NHS England requirements and activity and performance data will be submitted through national reporting systems as directed.

Recommendation
The Board is asked to **note** the vaccination plan.

An example of a weekly update in Connect, the newsletter for staff and volunteers

NHS
Queen Victoria Hospital
NHS Foundation Trust

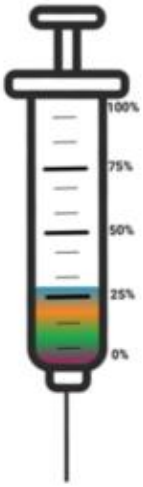
Have you had your flu jab yet?

Our annual staff flu vaccination campaign is well under way and **27% of staff** have received theirs already! Working within a hospital, we all have a responsibility to protect our patients, colleagues and ourselves and one way we can do this is to have a flu vaccination. It is safe, effective and quick to get. Most people have no side effects or just mild symptoms for a day.

We are running several drop-in clinics each week within **Occupational Health**, downstairs in the **Jubilee Building (Building 10),** and in the **Stay Well Room (Location 40)**. We also have a number of colleagues who are our roving vaccinators, visiting departments around the Trust.

The drop-in clinic dates for this week and next are:

- **Monday 19 October** 1.15 – 2.45pm, Occupational Health
- **Tuesday 20 October** 12 – 2pm, Stay Well Room
- **Wednesday 21 October** 10am – 12 noon, Occupational Health
- **Thursday 22 October** 12 – 2pm, Stay Well Room
- **Monday 26 October** 1.30-3.30pm, Occupational Health
- **Tuesday 27 October** 12-2pm, Stay Well Room
- **Wednesday 28 October** 10-11.30am, Occupational Health
- **Thursday 29 October** 12-2pm, Stay Well Room.



We appreciate staff may not want to be vaccinated for a variety of reasons. If you do not want your flu vaccination that is completely your choice but please can you let us know? There is a short online form to complete which will help us better understand why colleagues have declined as well as any additional support we could offer.

Had your flu vaccination already?
To help us manage how much vaccine we need, if you have already had your flu jab elsewhere, please let us know by emailing us.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026		**Agenda reference:**	**108-26**	
Report title:	Board Assurance Framework (BAF)				
Sponsor:	Jamie O'Callaghan, Interim Company Secretary, Executive risk leads				
Author:	Jamie O'Callaghan, Interim Company Secretary				
Appendices:	Appendix one- BAF summary, Appendix two- BAF				
Executive summary					
Purpose of report:	To present the Board Assurance Framework for review and approval of proposed reductions to strategic risk scores.				
Summary of key issues	• Following review through the Board committee structure, reductions are proposed to four strategic risk scores; no strategic risk scores are proposed to increase. • The proposed reductions reflect progress in relation to Estates Infrastructure, Sustainability & Strategy, Leadership Capacity and People and have been recommended by the relevant Board committees. • Financial Sustainability and Digital Transformation remain the Trust's highest-rated strategic risks and continue to require focused management attention. • The Board Assurance Framework continues to provide oversight of the principal strategic risks to delivery of the Trust's strategic objectives and the actions being taken to mitigate them.				
Recommendation:	The Board is asked to: • **Approve** the proposed reductions in strategic risk scores recommended by the relevant Board committees. • **Review** the Board Assurance Framework and consider whether it appropriately reflects the principal strategic risks facing the Trust.				
Action required	**Approval**	Information	Discussion	**Assurance**	**Review**
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	To deliver outstanding care	***To innovate and improve***	***To be an excellent employer***	***To deliver sustainable services***	***To collaborate with others***
Implications					
Board assurance framework:	Revised BAF to support delivery of KSO's				
Organisational risk register:	Links to organisational risks included in BAF				
Regulation:	CQC well led				
Legal:	None				
Resources:	None				
Assurance route					
Previously considered by:	ECQR, ELT and Board sub committees				
	Date:	Oct/Nov 2026	Decision:	Recommend	
Next steps:					

Board Assurance Framework (BAF)

1. Introduction

The Board Assurance Framework (BAF) sets out the principal strategic risks to delivery of the Trust's strategic objectives and the controls, assurances and actions in place to manage them. The BAF was last reviewed by the Board on 16 September 2026 and has subsequently been reviewed through the relevant committee structure. Following that review, four strategic risks are proposed to reduce in score and no strategic risks are proposed to increase.

Dedicated Executive Leadership Team review sessions continue to support collective oversight of strategic risks and identification of priorities for risk reduction.

2. Proposed Risk Score Changes

Since the Board's previous review of the Board Assurance Framework, the Executive Team and relevant Board committees have reviewed the current strategic risk profile, including the effectiveness of controls, assurances and mitigating actions. As a result of this review, reductions to four strategic risk scores are proposed for Board approval. No increases in strategic risk scores are proposed. The recommended changes are set out below.

Strategic Risk	Current Score	Proposed Score	Reason for Change
Estates Infrastructure	16	12	Progress in estates safety funding, compliance improvements and strengthened infrastructure management arrangements.
Sustainability & Strategy	15	12	Progress in strategic partnership implementation and organisational development activity.
Leadership Capacity	16	12	Progress in leadership arrangements, substantive appointments and organisational development activity.
People	12	9	Achievement of target score following continued workforce, leadership development and retention initiatives.

The relevant Board committees reviewed the proposed changes and recommended the revised scores for Board approval.

3. Strategic Risk Overview

Since the Board's previous review of the BAF, progress has continued across a number of strategic risk areas. Financial Sustainability and Digital Transformation remain the Trust's highest-rated strategic risks and continue to require focused management attention. Access also remains above target score, reflecting ongoing challenges associated with delivery of operational standards and recovery trajectories.

Estates Infrastructure and Quality have achieved their target scores, whilst improvements in Sustainability & Strategy, Leadership Capacity and People have supported the proposed reductions presented within this report.

Executive review has identified Financial Sustainability, Digital Transformation, Sustainability & Strategy and Leadership Capacity as the areas with the greatest influence on the Trust's overall strategic risk profile and future organisational resilience.

4. Heat Map

The heat map below provides a visual summary of the Trust's current strategic risk profile and highlights those risks which remain above target score and require continued oversight.

Likelihood	*Consequence*				
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain					
Likely				**Finance** **Digital**	
Possible			**People** **Quality**	**Access** **Cyber** **Estates** **Leadership Capacity** **Regulation** **Sustainability & Strategy**	
Unlikely					
Rare					

5. Actions Most Likely to Reduce Strategic Risk

As part of its review of the Board Assurance Framework, the Executive Team considered those actions most likely to reduce the Trust's overall strategic risk exposure and support delivery of the Trust's strategic objectives. Whilst each strategic risk has an associated action plan, the priorities set out below were identified as the areas where focused delivery is expected to have the greatest impact across multiple strategic risks during the remainder of 2026/27.

Strategic Priority	**Key Action**	**Risks Most Impacted**	**Expected Outcome**
1. Financial Sustainability	Deliver the financial recovery plan and recurrent efficiency programme	Finance, Sustainability & Strategy, People	Improved financial resilience and reduced reliance on non-recurrent measures
2. Digital Transformation and Cyber Resilience	Deliver Digital Strategy priorities, strengthen cyber resilience and develop	Digital Transformation, Cyber Security	Increased organisational resilience and digital maturity

	organisational resilience		
3. Strategic Partnership and Leadership	Deliver partnership implementation plans and embed leadership arrangements to support the Group model	Sustainability & Strategy, Leadership Capacity, Regulation & Governance	Stronger group arrangements and leadership capacity
4. Operational Recovery and Access	Improve cancer performance, reduce long waits and deliver specialty recovery plans	Access, Quality	Improved constitutional performance and patient outcomes
5. Infrastructure Resilience	Deliver estates investment programmes and maintain compliance and infrastructure resilience	Estates Infrastructure, Quality	Improved compliance and infrastructure sustainability
6. Workforce Sustainability	Deliver workforce retention, development and succession planning initiatives	People, Leadership Capacity	Improved workforce stability and leadership resilience

Delivery of these priorities will be critical to further reducing the Trust's strategic risk profile and supporting achievement of its strategic objectives. In particular, progress in relation to Financial Sustainability, Digital Transformation, Strategic Partnership delivery and Leadership Capacity is expected to have the greatest influence on the Trust's overall risk profile due to the extent to which these areas underpin performance across multiple strategic risks.

6. Overall Assurance

The Board Assurance Framework continues to provide a robust assessment of the principal strategic risks facing the Trust and the arrangements in place to manage them. The proposed risk score reductions reflect progress in a number of strategic risk areas and have been reviewed and recommended by the relevant Board committees.

While a number of strategic risks remain above target score and require continued oversight, the Board can take assurance that appropriate arrangements are in place to identify, monitor and manage the Trust's principal strategic risks.

7. Recommendation

The Board is asked to:

- **Approve** the proposed reductions in strategic risk scores recommended by the relevant Board committees.
- **Review** the Board Assurance Framework and consider whether it appropriately reflects the principal strategic risks facing the Trust.

.

Board Assurance Framework Summary – Updated 16 October 2026

Ref	Strategic Risk	Score			Trajectory	Assurance rating	Risk appetite	Board Commentary
		Inherent	Current	Target				
1	**Access** *Failure to deliver against the operational plan and national access standards*	16	12	8	⟷	Green (controls are effective)	Higher than risk appetite. Risk appetite for this area is cautious (4-6)	Ongoing challenges remain in relation to cancer performance, long waiting patients and delivery of operational standards. Recovery plans remain in place and Access continues to be a key area of Board focus due to its direct impact on patients and external scrutiny.
2	**Cyber** *Major cyber security incident impacting service delivery*	16	12	8	⟷	Green (controls are effective)	Lower than risk appetite. Risk appetite for this area is seek (15-20)	Assurance has strengthened following achievement of DSPT Standards Met. Cyber risk remains focused on organisational resilience, asset visibility and completion of the Information Asset Register.
3	**Digital** *Failure to deliver clinical, operational and financial objectives through digital transformation*	20	16	12	⟷	Amber (monitor and address)	Higher than risk appetite. Risk appetite for this area is seek (15-20)	Digital Transformation remains one of the highest-rated strategic risks. Principal challenges relate to sustaining digital transformation, securing future funding and maintaining programme capacity.
4	**Estates** *Estate deterioration impacting safe and sustainable service delivery*	20	12	12	↓	Green (controls are effective))	Within risk appetite. At target score	Estates has reduced from 16 to 12 and achieved its target score. Progress has been supported through estates safety funding, compliance improvements and recruitment to key estates posts.
5	**Finance** *Failure to achieve financial sustainability*	20	16	12	⟷	Amber (monitor and address)	Higher than risk appetite. Risk appetite for this area is minimal (1-3)	Delivery of recurrent efficiencies and achievement of a sustainable financial position remain the principal challenges. Progress continues through implementation of the recovery plan and development of the medium-term financial plan.
6	**Leadership capacity** *Insufficient leadership capacity to deliver strategic objectives and key projects*	20	12	8	↓	Green (controls are effective)	Higher than of risk appetite. Risk appetite for this area is minimal (1-3)	Leadership Capacity has reduced from 16 to 12 following implementation of revised leadership arrangements and appointment of the Group Chair and Group Chief Executive Officer.
7	**People** *Workforce sustainability and culture*	15	9	6	⟷	Green (controls are effective)	Within the range of risk appetite. Risk appetite for this area is open (8-12)	Workforce indicators remain broadly stable. The risk has reduced during the period, reflecting continued progress in workforce initiatives, although staff experience, culture and organisational change remain key areas of focus.
8	**Quality** *Failure to consistently deliver safe, high-quality care*	20	6	6	↓	Green (controls are effective)	Within risk appetite. At target score	Quality has achieved its target score and remains the strongest assurance position within the BAF. Quality governance, patient safety and patient experience arrangements remain strong.
9	**Regulation** *Failure to meet regulatory requirements*	20	12	8	⟷	Green (controls are effective)	Higher than risk appetite. Risk appetite for this area is minimal (1-3)	Regulatory assurance remains stable, supported by positive internal and external assurance, strong policy compliance and continuing improvements in governance processes.
10	**Sustainability and strategy** *Failure to secure long-term organisational sustainability*	20	12	9	↓	Green (controls are effective)	Higher than risk appetite. Risk appetite for this area is open (8-12)	Sustainability & Strategy has reduced from 15 to 12 following progress in strategic partnership implementation, leadership arrangements and development of future governance arrangements.

BAF001 - ACCESS

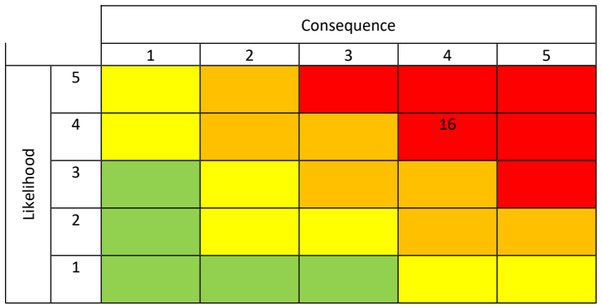
KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27	Q3- 2026/27	
✓			✓	✓							

BAF

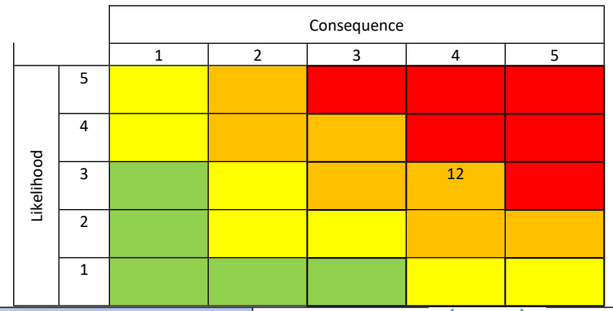
Risk description
Risk:
There is a risk that the Trust will not deliver against its operational plan and national access standards
Caused by:
Rise in waiting lists; increased demand; national changes;
Resulting in:
Patients waiting longer than we would like for treatment; potential patient harm/ poor experience; widening health inequalities; the Trust not achieving its operational plan; reputational damage; increased NHS oversight

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief operating officer	**Date Risk last reviewed:**	15 October 2026		
Risk Handler(s)	Deputy Chief operating officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Trust Board

Inherent Score



Current Score



Target Score



Direction of travel since last review		**Target date**	31 March 2027
		Risk tolerance	Current risk score outside of risk appetite (higher) (cautious)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Monitoring against the operational plan 2026/27 weekly internally and externally with action plans for improvements	1st line: Cancer Board continues to monitor delivery of the Cancer Action Plan monthly. QVH and the Surrey & Sussex Cancer Alliance have mapped the skin cancer pathway, with a revised joint action plan presented in April 2026. A Cancer Project Manager has been appointed until the end of 2026 to support improvements to the skin cancer pathway and, from November 2026, the head and neck pathway. While the overall cancer position remains challenged, improvements in Faster Diagnosis Standard (FDS) performance are expected from September 2026. 31-day performance is on track. October 2026 Amber Recovery plans remain in place to address performance challenges arising from increased demand, capacity pressures across Sleep, Skin and Oral &	NHSE strategic review of breast reconstruction- the Trust has indicated wanting to be a key player within this. Breast is still challenged due to the national capacity constraints.

	Maxillofacial services, and constraints within Plastic Surgery. Enhanced operational oversight, supported by strengthened leadership, is helping to improve operational grip and control, with a continued focus on improving patient access and recovering performance. October 2026 Amber 2nd line: Monthly reporting and monitoring through the IQPR demonstrates ongoing challenges with 52 week waits and 18 week wait performance. For cancer, FDS 62 day and 31 day are currently challenged. August 2026 Amber/ Red (see action 2 and 8) 3rd line: Internal audit on FDS demonstrates reasonable assurance with a good control framework in place. The 2026 audit is on skin cancer 62 day is in progress. October 2026, Green LUNA Data Quality Assessment demonstrates high confidence levels at 99.71%, October 2026, Green National Oversight Framework rating by NHSE. The Trust was rated 2/ 134 trusts for performance overall for Q1 2026/27, October 2026, Green	
Governance and oversight incl. weekly tracking list meeting, weekly operational performance meeting, system planned care meeting, monthly access and performance meeting. Weekly focused recovery assurance meetings for sleep and plastics	2nd line: Monthly alert, assure, advise reporting to the ECQR from the Access and Responsiveness executive sub-committee demonstrates grip and control, appropriate oversight and escalation, October 2026, Green Independent review of waiting list management and governance carried out in March/April 2026, with recommendations highlighting key areas for improvement required in some services. October 2026. Amber (See Action 11)	
Clinical harm review process with CMO reviewing patients over 78 weeks. Metrics and learning on harm from delays in cancer pathways shared at Cancer Board	1st line: Weekly review of long waiting cancer patients in place. No confirmed moderate or greater than moderate harm confirmed, but noting longer wait impact for patient experience, October 2026, Amber (see action 4) Process established within cancer care pathways for harm from delays to be clinically evaluated resulting in targeted action and shared learning reported to Cancer Board. Reporting through Quality Committee to ECQR and by exception to Quality & Safety Committee demonstrates targeted action and shared learning, October 2026, Amber (see action 4)	Clinical Lead for Cancer has responsibility and oversight of progress in this metric where clinically required.
Health inequalities priorities improving data collection around ethnicity and processes for patients under the mental capacity act	1st line: Biannual paper to Board on addressing health inequalities highlights actions with the capture of ethnicity data, and progress made against the HI Quality Priority for 26/27, Green (see actions 3, 6 and 7)	Data for patients with other protected characteristics due to patient administration system. Impact on health inequalities work for patients.

	Paper on health inequalities discussed at Quality and Safety Committee in Q4 2025/26 with progress on developing a HI dashboard. HI Focus Areas identified progression relating to Deprivation / DNA impact in regard to both PTL reporting and targeted review for Medway spoke site patients. Amber (See Action 11)	
Access policy, booking policy, training manual for appointments staff, EPRR policies in place	2nd line: Internal review of policies demonstrates the majority of operational policies are in date and have been reviewed against most recent guidance Green EPRR annual assurance to Board demonstrates Substantial compliance. EPRR assurance process complete for 25/26, rating due in December 2026 Green 3rd line: Internal audit on faster diagnosis standards demonstrates reasonable assurance with a good control framework in place. The 2026 audit is on skin cancer 62 day is in progress. October 2026, Green	Currently reviewing the Access Policy.

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Improvements to teledermatology pathway to improve capacity within skin. QVH part of Sussex dermatology transformation work to look at single point of access from 2027.	April 2026	COO	Complete
2. QVH to inform the NHSE strategy regarding commissioning of breast reconstruction services across the South East. Internally, continue prioritisation of long waiting patients.	January 2027	COO	In progress, conversations with NHSE have commenced. Paced impacted by NHSE restructures
3. Use the Health Inequalities Task and finish Group to continue to prioritise ethnicity recording, and to work through actions to reduce inequalities where these are known, e.g children with long waits.	February 2026	CNO	Complete
4. Completion of clinical review of harm for cancer patients with long waits	January 2026	CMO	Complete
5. Develop oversight and reporting for non-RTT waits	April 2026	COO	Complete
6. Health inequalities data for patients with protected characteristics	February 2026	CNO	Complete
7. Provide assurance about the impact on health inequalities work completed to date and yet to be completed for patients	February 2026	CNO	Complete
8. Revisit action plans to address issues with 65 week waits to address any internal pathway challenges	October 2026	COO	Action plans in place, revised trajectories for non-breast patients with exception of late referrals
9. Revisit action plans to improve cancer performance to meet 2026/27 plan	November 2026	COO	Subject to monthly review and update
10. Delivery of recovery action plan	Ongoing	COO	Ongoing – in progress
11. Further review of actions required for 8 to incorporate waiting list review recommendations	June 2026	DCOO / COO	Complete
12. Targeted HI work programme	Ongoing	CNO	Ongoing

Links to Organisational Risk Register	Risk 77 (patients coming to harm whilst waiting for treatment), 88 (compliance with standards in relation to performance)

BAF002 - CYBER

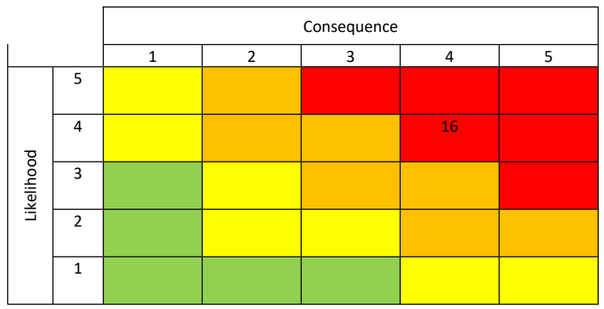
KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q1- 2026/27	Q2- 2026/27	Q3- 2026/27	Q4- 2026/27		
✓	✓		✓	✓							

BAF

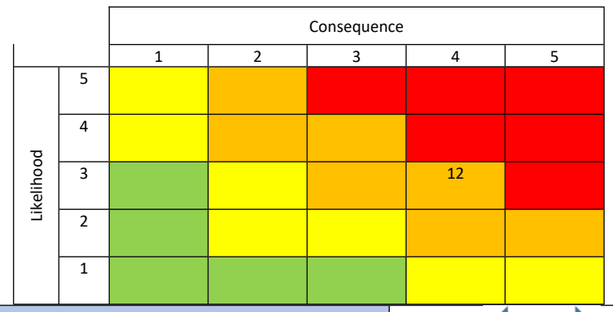
Risk description
Risk:
There is a risk that the Trust may experience a significant cyber security incident;
Caused by:
Increasing cyber threats, legacy infrastructure, reliance on third-party suppliers and limitations in specialist cyber capacity and funding;
Resulting in:
Disruption to clinical and operational services, compromise of patient or staff data, patient safety impacts, financial loss, regulatory non-compliance, and reputational damage.

Responsible committee	Audit and risk committee	**Date Risk Added:**	03 June 2026		
Principal Exec – Risk Owner	Tamara Everington, Chief medical officer	**Date Risk last reviewed:**	06 October 2026		
Risk Handler(s)	Bill Gordon, Chief digital information officer	**Date Risk last formally discussed:**	09 July 2026	**Group**	Trust Board

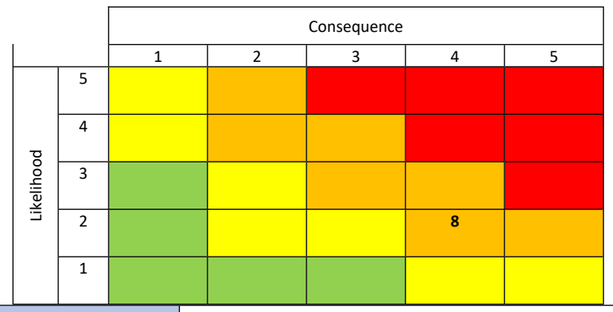
Inherent Score



Current Score



Target Score



Direction of travel since last review	⟷	**Target date**	31 December 2026
		Risk tolerance	Current risk score outside of risk appetite with a lower score (seek)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
CAF-aligned DSPT framework CAF-aligned Data Security and Protection Toolkit (DSPT) framework in place, with an annual submission and an agreed improvement plan.	1st line: Regular reporting to the Audit & Risk Committee on progress against the DSPT CAF improvement plan demonstrates continued delivery of planned actions and strengthening of cyber controls, Green 2nd line: Annual DSPT CAF submission confirms the Trust is now "Standards Met". Green	Full assurance can be achieved now we have achieved "Standards Met" and all DSPT CAF improvement actions have been completed and independently validated. Ongoing assurance is required that improvements are embedded and sustained beyond the reporting period.
Cyber Security Operations Centre (CSOC) monitoring Cyber Security Operations Centre (CSOC) monitoring in place for national cyber alerts, with formal processes for review and response	1st line: Reporting to the Audit & Risk Committee demonstrates that cyber security alerts are reviewed, acknowledged and responded to within required national timescales, Green 2nd line:	Continued assurance is required that monitoring arrangements remain effective as the cyber threat landscape evolves. Limited independent assurance over the effectiveness of third-party monitoring arrangements.

	Regular updates to governance committees demonstrate continued oversight of cyber threats and appropriate escalation processes, Green	
Independent cyber security testing Annual independent cyber security testing undertaken by appropriately accredited external providers.	3rd line: Annual independent cyber security testing demonstrates that technical controls are subject to external scrutiny, with identified issues tracked through formal remediation plans and reported to the Audit & Risk Committee, Green	Assurance is point-in-time and dependent on testing cycles, with gaps between formal reviews. Full assurance dependent on timely completion and validation of remediation actions arising from testing.
Vulnerability and patch management Formal vulnerability and patch management processes in place, supported by infrastructure modernisation and system upgrades.	1st line: Regular reporting to the Audit & Risk Committee demonstrates active management of cyber vulnerabilities, including progress in addressing legacy systems and implementing system upgrades, Green 2nd line: Oversight through governance arrangements demonstrates that remediation plans are in place and being monitored, Green	Residual risk remains from legacy systems and technical debt where full remediation has not yet been achieved. Ongoing assurance required that vulnerability management processes are consistently effective across all systems.
Information Asset Register Information Asset Register programme in place to identify and manage digital and connected medical assets.	1st line: Programme reporting demonstrates progress in developing a comprehensive Information Asset Register, including identification of digital and connected medical assets, Amber 2nd line: Alignment with DSPT CAF requirements demonstrates that asset management controls are being developed in line with national standards, Amber	Full assurance cannot be provided until the Information Asset Register is complete, validated, and regularly maintained. Limited assurance over the security of all network-connected assets, including medical devices, until full visibility is achieved.
Cyber incident response and exercising Cyber incident response and business continuity arrangements tested through scheduled cyber tabletop exercises	1st line: Reporting to the Audit & Risk Committee demonstrates that cyber incident response arrangements are tested through scheduled tabletop exercises, with learning identified and tracked, Green 2nd line: Executive oversight demonstrates that lessons learned from exercises are incorporated into organisational processes, Green	Assurance is based on planned and periodic exercises; further testing is required to ensure sustained organisational readiness. Ongoing assurance required that lessons learned from exercises are embedded consistently across services. Noting threat to NHS key digital vendors, work with our vendors to ensure threat prevention measures are in place.

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Completion of DSPT CAF improvement plan and embedding of controls	30 June 2026	CDIO	Complete
2. Ongoing reporting of cyber security position to Audit & Risk Committee	Ongoing	CDIO	Ongoing
3. Annual independent cyber security testing and review of outcomes	30 June 2026	CDIO	Complete
4. Completion and validation of the Information Asset Register for essential functions	Ongoing	CDIO	In progress
5. Delivery of annual scheduled cyber incident tabletop exercise and tracking of agreed actions	31 January 2027	CDIO	In progress
6. Continued infrastructure modernisation to reduce cyber risk from legacy systems	Ongoing	CDIO	Ongoing
Links to Organisational Risk Register	Digital risk register / BAF		

BAF003 - DIGITAL

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27	Q3- 2026/27	
✓	✓		✓	✓							

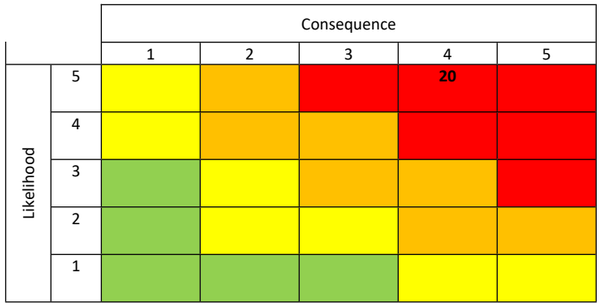
BAF

Risk description

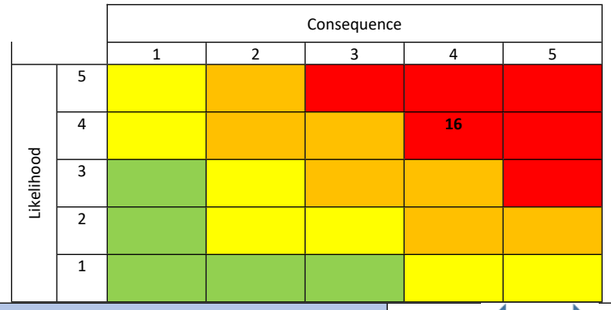
Risk:
There is a risk that the Trust may not be able to deliver its clinical, operational and financial objectives due to insufficient progress in digitisation
Caused by:
Constraints of capital and revenue funding to support people and resources required to sustain, develop and transform digital working including lack of funding for digital transformation roles past December 2026 with loss of some roles end June 2026;
Resulting in:
Nonalignment with the national priority to move from analogue to digital; reputational damage; potential non-realisation of benefits from digitisation; impact on service delivery and quality

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Tamara Everington, Chief medical officer	**Date Risk last reviewed:**	06 October 2026		
Risk Handler(s)	Bill Gordon, Chief digital information officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Trust Board

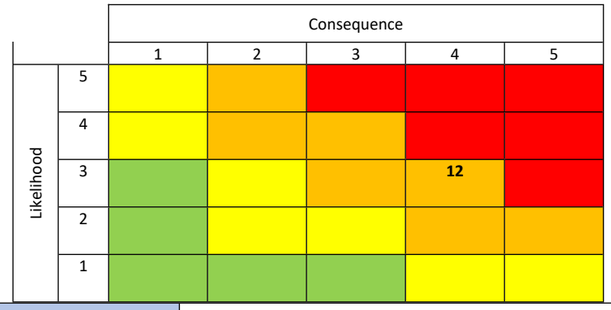
Inherent Score



Current Score



Target Score



Direction of travel since last review	⟷	**Target date**	31 December 2026
		Risk tolerance	Current risk score outside of risk appetite and imminent risk of deterioration end June 2026

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Digital strategy incl. alignment of digital transformation with EPR programme	1st line: Regular reporting on Digital Transformation through monthly IQPR and progress updates on the Digital Transformation Programme to the FPC, Green 2nd line: Biannual reporting through ELT to the Strategy and Culture Committee with reflection on clinical governance components in the Quality and Safety Committee, report provided for discussion at SCC 2 June 2026, Green	Review of digital strategy required as strategic partnership develops Development of the data strategy working with system partners SMART strategic objectives aligned to prioritisation and available funding subject to ongoing review and as funding opportunities arise.
Digital policies and procedures	1st line: Policy report to ECQR demonstrates no digital policies out of date, however, this will need to be kept under regular review Green	

	2nd line: DSPT and CAF annual submission for standards met demonstrates the Trust is Standards Met. RSM audit review June 2026 completed with no further actions identified.	
Organisational resilience in the event of digital systems failure	1st line: Regular review / refresh as needed of business continuity plans to ensure ongoing service provision in the event of system failure Amber 2nd line: Scheduled EPRR simulation events to test resilience. Lessons learnt with actions following unplanned outage. EPRR lead now in post from September 2026 Amber	Systematic process aligned to Information Asset review to be developed to ensure assets, especially essential system assets have an in date BCP. Review lessons learnt from unplanned outage. Plan EPRR simulation events.
Horizon scanning for digital funding with NHSE incl. commissioning intentions	1st line: Discussion with NHSE about medium term planning- no confirmation about future funding, bids submitted to Frontline Productivity and Wayfinder calls May 2026, Green 3rd line: Commissioning intentions for 2026/27 demonstrate a continued commitment to driving digital transformation and plans to address duplication in digital infrastructure with opportunities to share costs and functions across the system for implementation from 1 April 2026, ongoing discussions with ICB / NHSE, Amber	Trust reliant on external funding to progress. Internal funding agreed until 31 December 2026. Engagement with ICB Digital Strategic Commissioning Enablement Lead.
Workforce with specialist digital and technical skills to support digitisation	1st line: Core Trust IT require further development of specialist technical skills. Contractors and internal staff on secondment to support Digital Transformation Programme programme internally funded until December 2026 with some stepdown from June 2026. Amber 2nd line: Outsourced functions to 3rd party providers through managed service contracts. Contract monitoring processes in place, Green	Time limited resource with no confirmation of long-term funding. Internal funding agreed until December 2026. Management of change to include identification of skills requirements for specific roles by January 2027.

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Digital strategy will need to be refreshed as partnership / system strategy develops, data strategy to develop with system	1 December 2026	CDIO	Pending
2. SMART objectives to be refreshed as strategic priorities evolve / funding becomes available	1 December 2026	CDIO	Pending
3. Review of RSM DSPT/CAF assurance report June 2026, address any required actions	30 June 2026	CDIO	Complete
4. Ongoing engagement with NHSE and ICB around funding intentions for digital	31 March 2027	CDIO	Ongoing
5. Management of change to include identification of skills requirements for specific roles by October 2026.	31 December 2026	CDIO	Ongoing
6. Regular reporting to the Finance and performance committee	31 March 2027	CDIO	In progress / ongoing
7. Ensure digital policies are consistently updated and approved through governance routes	31 March 2027	CDIO	Complete / ongoing
8. Systematic process aligned to Information Asset Register review to ensure BCPs for essential systems are in place and updated. Review lessons learnt from unplanned outage. Plan EPRR simulation events.	1 December 2026	COO/CDIO	Pending
Links to Organisational Risk Register	138 (failure to deliver EPR programme)		

BAF004 - ESTATES

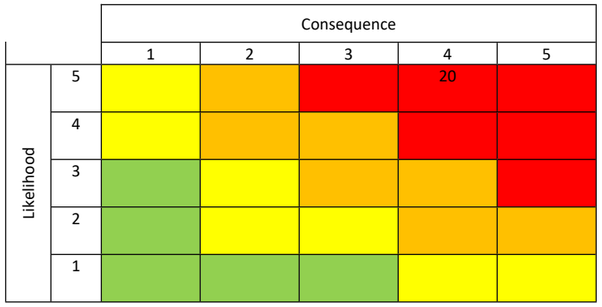
KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1 2026/27	Q2 2026-27	Q3 2026/27	
✓			✓								

BAF

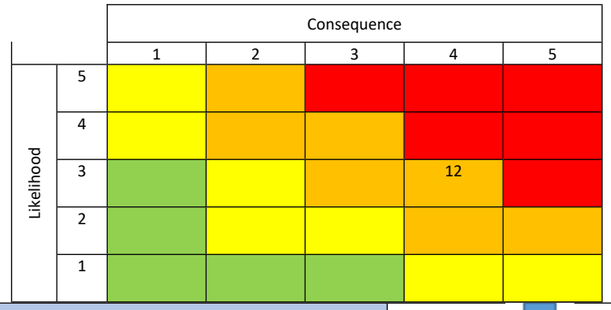
Risk description
Risk:
There is a risk that the Trust's estate deteriorates to the point where it is no longer safe
Caused by:
Ageing estate; poor quality of previous work completed; limited capital resource to address critical infrastructure challenges; maintenance and repair backlog; estates team resource challenges; lack of compliant ventilation
Resulting in:
Harm to individuals; Potential impact on service delivery; services no longer being delivered from the QVH site; financial loss; reputational damage.

Responsible committee	Finance and Performance committee	**Date Risk Added:**	10 November 2025		
Principal Exec – Risk Owner	Chief People officer	**Date Risk last reviewed:**	12 October 2026		
Risk Handler(s)	Interim Director of Estates and Facilities	**Date Risk last formally discussed:**	16 September 2026	**Group**	Trust Board

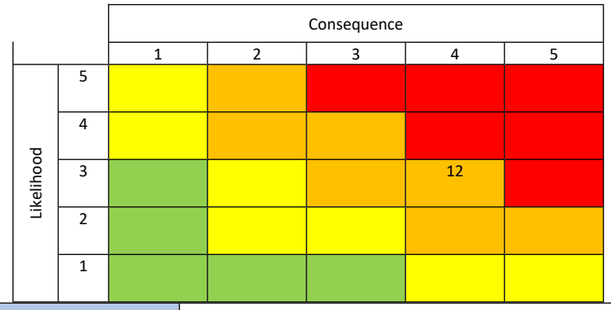
Inherent Score



Current Score



Target Score



Direction of travel since last review		Target date	31 March 2027
		Risk tolerance	Current risk score within risk appetite (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Estates policies and processes in place to support compliance with statutory requirements	1st line: Regular reporting on the Trust's estate to the Finance and Performance committee demonstrates that works are completed are in line with statutory requirements, October 2026, Green 2nd line: Regular report regarding out of date policies to the ECQR. Following the E&FSC meeting on 26th March, estates up to date on policies. August 2026 June 2026, all policies up to date Green (see action 6)	

	Policy log demonstrates that key estates policies are in place to support compliance with statutory requirements, March 2026. June 2026 Policies are all in date. Green (see action 6) Premises Assurance Model (PAM) completed annually and reported to the Finance and Performance committee and the Board demonstrates significant improvement from the previous year with action planning for further improvements underway, New digital collection system is in the process of being launched March 2026. June 2026, PAM has been updated for 2026, with additional questions and evidence of compliance requirements. August 2026, PAM completed, reporting to Finance and Performance Committee 1 September 2026 ahead of NHSE Submission. Reported at Trust Board 16 September 2026. Submitted to NHSE September 2026 Green 3rd line: Authorised engineer (AE) review on water compliance was completed in September 2025 and the report is being actioned. August 2026 – new water AE appointed Authorised engineer (AE) review on ventilation compliance was completed in December 2025 and the report is being actioned. August 2026 – AE report reviewed by the ventilation group	
Estates capital funding plan to ensure prioritisation of works in line with risks	1st line: Regular reporting on the Trust's estate to the Finance and Performance committee demonstrates limited funding available to appropriately address critical infrastructure risks, March 2026, Green (see action 2). Receipt of the additional £2.8m of estates safety funding in 2025/26 and £3.6m in 2026/27 required to support estates critical infrastructure work. June 2026 – funding not yet received from NHSE for 2026/27. July 2026 – funding confirmed Green 2nd line: Review of estates budget by management accountant demonstrates that the directorate is in budget at this stage of the year, October 2026, Green (see action 2). June 2026, capital budget is limited for 2026/27, awaiting estates safety funds for 2026/27 to support delivery of essential maintenance. July 2026 – funding confirmed Green Regular reporting on financial performance through the IQPR demonstrates that the estates capital budget fully spent at March 2026, Green (see action 7) August 2026 – regular reporting via Finance and Performance Committee – on track to utilise all capital funds - Green 3rd line:	

	£2.8m of estates safety funding received in November 2025, Green (see action 2) August 2026 - £2.4m of estates safety funding confirmed in July 2026 Green	
Business continuity plans for dealing with a range of issues, for example critical infrastructure failure	2nd line: EPRR annual assurance to Board demonstrates full compliance, Green	
Asbestos management plan in place to meet the statutory requirement of CAR 2012 (Control of Asbestos Regulations)	1st line: Regular review of Management Plan by estates leadership incl. visual inspection of asbestos areas demonstrates a requirement to remove certain asbestos contained roofing materials (ACM's) within six months. Amber. June 2026, work has been completed on a replacement roof for the estates building. Ongoing asbestos removal continues – October 2026 3rd line: The Management Plan is reviewed annually by an external specialist contractor. Review undertaken in November 2025. Green Regular testing (refurbishment and demolition surveys) to identify asbestos prior to any building or repair works being undertaken, demonstrates no works to be undertaken in unsafe environment, November 2025, Green	
Estates team and key roles with appropriate qualifications to manage the Trust's estate	1st line: Review of team demonstrates that key roles are in place including Associate Director of Estates and Facilities, Project managers and Compliance Manager, however there are gaps in expertise relation to electrical and mechanical, March 2026. June 2026, Fire Safety Officer, Waste Compliance Manager and Compliance Co-ordinator roles have been appointed / have started in their roles. Mechanical and electrical specialist roles remain unfilled, with reliance on contractors due to these gaps. Amber (see action 4).August 2026 – electrical engineer appointed.	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Statutory Fire advisor role to be recruited to	31 March 2026	ADEF	Successful candidate started May 2026 - completed
2. Seeking additional funding from NHSE for funding for critical infrastructure risks	30 June 2026	DEF	Notification on 10 June funding approved - complete
3. Arrange for a six facet survey to be completed	31 July 2026	DEF	Contract awarded
4. Appointment of replacement authorised engineers (AE) to be completed	31 October 2026	DEF	Replacement of AEs being undertaken by DEF. Work ongoing – replacement of water and medical gas engineers

BAF004 - ESTATES

5. Review of estates specific business continuity plans	30 ~~September~~ November 2026	ADEF	Underway – reviews of plans / updates being undertaken by ADEF / DEF
6. All estates policies to be updated in line with requirements	31 March 2026	ADEF	Completed
7. Continued oversight of estates capital spend to support year end position	31 March 2026	CFO	Completed
8. Complete Estates Bench marking compliance review	30 September 2026	DEF	Completed
9. Compliance report for electric, water, ventilation, fire to be produced	30 September 2026	DEF	Completed
Links to Organisational Risk Register	153 (spread of fire), 139 (electrical fire), 47 (failure of electrical systems), 48 (fire alarm), 49 (fire dampers), 53 (heating and hot water)		

BAF005 - FINANCE

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27	Q3- 2026/27	
✓	✓	✓	✓	✓							

BAF

Risk description

Risk:

There is a risk that the Trust will not deliver the full value of its £7.5m cost improvement plan for 2026/27 and cost improvement plans for future years; deliver a breakeven position for 2026/27 and for future years and/ or that the working cash balance will reduce to lower than £1m.

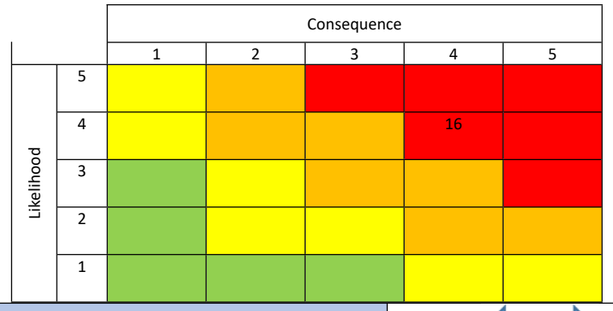
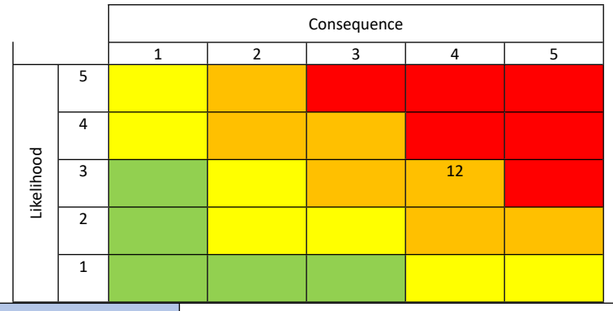
Caused by:

The Trust's significant cost improvement target of £7.5m for 2026/27 including the requirement for corporate service cost reductions; changes to the funding regime including capping of income levels; significant activity levels, and financial pressures across other NHS organisations delaying payments.

Resulting in:

The Trust not being financially sustainable for the future.

Responsible committee	Finance and performance committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief Finance Officer	**Date Risk last reviewed:**	6 October 2026		
Risk Handler(s)	Deputy Chief Finance Officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Trust Board

Inherent Score	Current Score	Target Score
		
	Direction of travel since last review	**Target date** 31 March 2027
		Risk tolerance Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Efficiency Steering Group (ESG) is charged with overseeing the Better Value Programme, including the identification of productivity and efficiency opportunities, ensuring that approved schemes are developed through to implementation including the completion of QIAs where necessary. The ESG is also responsible for the tracking	1st line: Reporting on progress of the cost improvement programme through the Efficiency Steering Group, Finance and Performance committee and Board. This shows the delivery against the programme and illustrates the level of development of the programme along with completion of individual POAPs, Amber (see action 1)	Assurance that recurrent savings can be made. Currently, some non-recurrent in 2026/27 and savings yet to be identified for 2026/27.

and reporting of delivery of schemes and any remedial actions where needed.	2nd line Regular reporting on finance through the IQPR. This demonstrates delivery against programme and key corrective actions being taken, but with more being delivered non-recurrently than planned, June 2026, Amber (see action 1)	
Regular oversight of overall financial position incl. regular reporting to the Resources and Financial Control Groups	1st line: Regular reporting and review of financial management arrangements, including revenue, capital, VAT, NI, ERS, balance sheet items and cash flow actuals & forecasts and the accounting treatment of significant transactions, Green 2nd line: Regular reporting on divisional financial performance, through the IQPR demonstrates that to date, the Trust is not on track for its breakeven target, August 2026, Amber	In-year recovery plan not yet in place to decrease the gap either recurrently or non-recurrently to try and achieve a breakeven position by the end of the year.
Financial policies including Standing Financial Instructions, Scheme of Delegation, Contract policy and Procurement policy	1st line: Regular reporting to the Audit and Risk committee regarding compliance with policies including waiver report and PO compliance report. This demonstrates a reduced number of waivers supporting better value for money and the percentage of non-PO's being less than 1% of invoices, June 2026, Green 2nd line: Regular report regarding out of date policies to the ECQR demonstrates no finance policies being out of date, June 2026, Green 3rd line: Internal audit on compliance with governing documents and policies concluded reasonable assurance with considerable progress and strengthening of controls and value for money, June 2026, Green External audit concluded that there were no findings in relation value for money, June 2026 Green	Assurance that staff across the organisation understand their responsibilities. Assurance that the compliance position has materially improved long term. Quarterly reviews demonstrate compliance to date.
Medium term financial plan in development to support a forward view	The Trust has submitted its 5 year MTFP which has been accepted and has the plan for 2026/27 along with indicative plan for the following 2 years. but significant amounts of internal and system work are still to be undertaken, Green The plan for 2027/28 and onwards will need to additional work in the future to further develop the plans and take account of changes in year. This will also need to be built to deal with changes to national expectations and financial control environment. Amber (see action 3)	
Annual business planning process incl. budget setting	1st line: Business plans are submitted to Finance Performance committee and Board which each year in the 2026/27 plans going forward demonstrates planned	

	breakeven position, however this is not without risk, June 2026, Amber (see action 1) Report to ELT on the business planning approach for 2027/28 along with learning from the previous years planning process, October 2026, Green 2nd line: Fortnightly review of business planning progress by business planning group worked well and will be continued in the 2027/28 planning and will be used again to monitor delivery and triangulation of plans Will need to be further developed for 2027/28, June 2026, Amber	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Continued identification of cost improvement programmes and conversion of non-recurrent to recurrent schemes	Ongoing	CFO	Ongoing
2. Develop Governance handbook to support staff across organisation	30 September 2026	CS	First draft Complete
3. Medium term financial plan development following 1st year of the plans	Q3/Q4 2026/27	CFO	Plan for year 2 to be updated and refreshed for 2027/28 planning.
4. Dashboard for financial assurance within the Audit and Risk committee to facilitate the compliance review	Q3/Q4 2026/27	DCFO	On track – draft has been created for comments
5. To compile and implement an in-year recovery plan to achieve breakeven at 31 March 2027	Ongoing	CFO	On track
Links to Organisational Risk Register	161 (cash balance), 148 (CIP), 149 (ERF assumptions), 144 (delivery of breakeven plan)		

BAF006 – LEADERSHIP CAPACITY

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27	Q3- 2026/27	
✓	✓	✓	✓	✓							

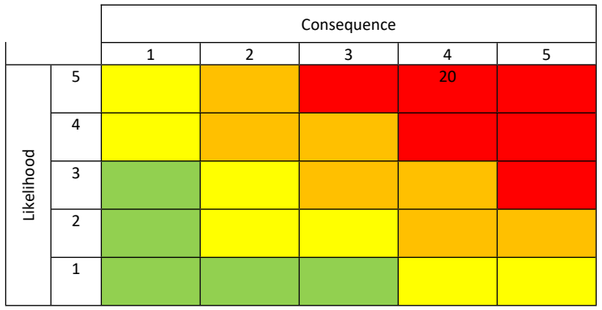
BAF

Risk description

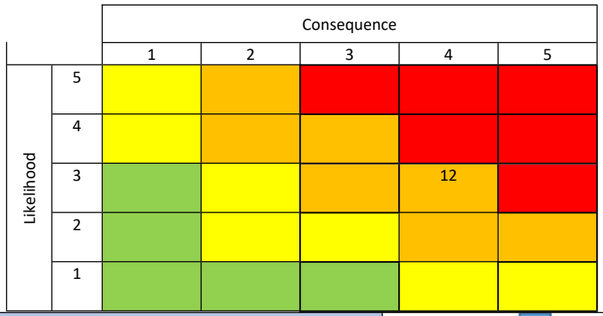
Risk:
There is a risk that there will not be leadership capacity to deliver the strategic partnership, key strategic objectives and key projects
Caused by:
Four interim executive roles including Chief executive officer; turnover in Board level roles and organisational memory loss; three Non-executive directors coming to end of terms in June 2026
Resulting in:
Closure of services/ site; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings

Responsible committee	Strategy and culture committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief executive officer	**Date Risk last reviewed:**	06 October 2026		
Risk Handler(s)	Chief executive officer	**Date Risk last formally discussed:**	09 July 2026	**Group**	Board

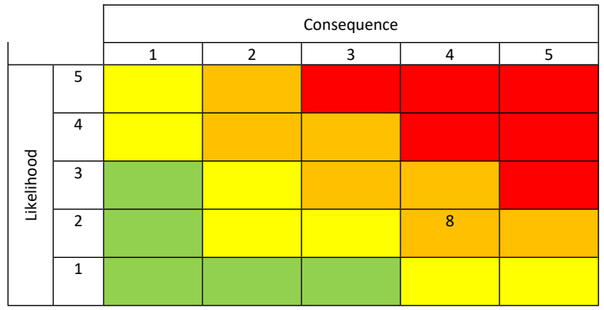
Inherent Score



Current Score



Target Score



Direction of travel since last review		**Target date**	March 2027
		Risk tolerance	Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Key Board level roles being filled incl. executive portfolios covering all areas of operational business	1st line: Review of Board roles demonstrates all roles currently filled with some executive roles being filled by interims to ensure the required level of experience required. Amber Group Chair and Deputy Chair to commence from October 2026, Green Board succession plan presented to the Nomination and remuneration committee demonstrates a limited succession pipeline for key roles, September 2026, Amber (see action 2) Chief strategy officer role has been filled on an interim basis, April 2026, Green Managing Director in post from September 2026, Group CEO in post from October 2026 Green	Board skills and maturity matrix to be reviewed in December 2026 Interim /acting up roles within executive team need to be substantiated

BAF006 – LEADERSHIP CAPACITY

Programme of work to deliver strategic partnership incl. timeline	1st line: MoU now signed by all ASPH/RSFT/QVH, Green Reporting to the Strategy and Culture committee outlining the timeline demonstrates that the Trust is meeting milestones, Green Transition and implementation plan was shared with Strategy and culture committee in February 2026, demonstrates commencement of workstreams and finance and governance reviews, Green 3rd line: Review of NHSE timeline demonstrates alignment with QVH timeline, October 2025, Green	
Monitoring of progress against strategic projects incl. project management office function in place to support this	1st line: Update to Board to confirm the EPR Go Live has been a success with no patient cancellations, November 2025, Green	
Key strategic objectives and priorities	1st line: Reporting to the Board demonstrates good progress against the key strategic objectives and priorities for 2025/26, March 2026, Green Key strategic objectives for 2026/27 due to be approved by the Board in May 2026. KSOs are aligned to national and QVH specific strategic priorities, May 2026, Green	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Shared Chair and CEO to be in post by October 2026	~~March 2026~~ October 2026	CoSec	Complete
2. Explore opportunities for sharing corporate services and key roles	Ongoing	Group CEO	On track
3. Interim Chair arrangements from January 2026 to be agreed	December 2025	SID, CoSec	Complete- interim Chair appointed
4. Project benefits realisation tracking to be developed	March 2026	DCSO	Complete
5. Non-executive director arrangements from June 2026 to be agreed	January 2026	Group Chair, CoSec	Complete
6. Board skills and maturity matrix to be reviewed	~~June 2026~~ December 2026	Group Chair, CoSec	On track
7. Confirm Chief finance officer cover from June 2026	May 2026	CEO	Complete- shared interim CFO with RSFT
8. Confirm and action revised leadership arrangements from October 2026	October 2026	Group CEO	Complete
9. Substantiate interim/acting up roles within executive team	March 2027	Group CEO/MD/CPO	On track

Links to Organisational Risk Register	11 (relationship between Board and Council of Governors)

BAF007 - PEOPLE

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27	Q3- 2026/27	
		✓									

BAF

Risk description

Risk:

There is a risk that the Trust is unable to fulfil its commitment to being an excellent employer and may not have a workforce fit for the future

Caused by:

Significant organisational change; uncertainty; the Trust's significant cost improvement target; requirement for corporate service cost reduction; leadership capacity and managers capability

Resulting in:

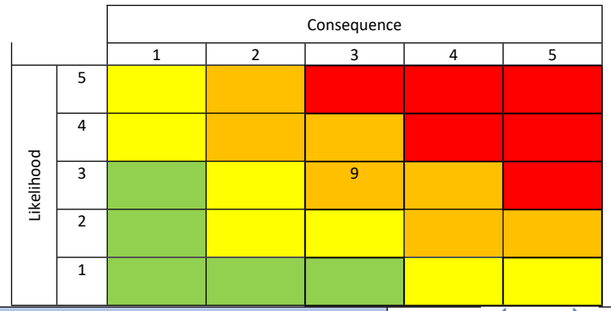
Staff turnover; single points of challenge and lack of resilience; challenges with recruitment and retention; challenges with organisational culture; a negative effect on staff wellbeing and motivation; non-delivery of key strategic objectives and projects; impact on quality

Responsible committee	Strategy and culture committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief people officer	**Date Risk last reviewed:**	12 October 2026		
Risk Handler(s)	Deputy Chief people officer	**Date Risk last formally discussed:**	16 September 2026	**Group**	Board

Inherent Score



Current Score



Target Score



Direction of travel since last review	⟷	**Target date**	July 2026
		Risk tolerance	Current risk score within risk appetite (open)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Staff wellbeing support and programmes incl. occupational health, EDI champions, Vivup, Wellbeing team initiatives, monthly newsletter promoting annual wellbeing calendar ands wellbeing events and support	1st line: Data showing staff sickness and type. Data shows c.4% sickness level with an increase in long term sickness, October 2025. Sickness data shows sickness at 4.2% for April 2026, with long-term sickness being a driver of the sickness rates. October 2026 sickness remains at 4.2% with higher rates in theatres, with focussed support in place Amber Reporting to CTSG demonstrates progress towards using continuous improvement methodology to improve culture and challenges experienced by EDI champions with	EDI staff networks not up and running. Linked with partner organisations to share learning / share staff networks.

	engagement, October 2025. CTSG will be re-focussed from April 2026, with a clear focus on speaking up and psychological safety, May 2026. October 2026, CTSG will be re-starting Amber 2nd line: 2024 Staff survey results published in March 2025 with a 57% response rate, demonstrate disabled staff have a less positive experience than non-disabled staff and staff do not always feel confident action will be taken if they speak up. 2025 staff survey published in March 2026 and reported to the Strategy and Culture Committee and Board in May 2026. Update paper relating to areas of focus being taken to the Strategy and Culture Committee in September 2026 Green People Pulse Survey for 2025/26 (up to January 2026) was responded to by 474 staff. In Q4 139 (10.7%) staff completed the People Pulse Survey. The Q4 results demonstrated an improvement in mood and motivation. Q1 2026/27 People Pulse Survey results will be reported to the Strategy and Culture Committee in August 2026 Green	
Staff development and training incl. coaching, mentoring, change management workshops, resilience workshops	1st line: Executive sub-committee for Workforce regular assurance report to ELT includes staff development and training data, demonstrates a good take up from clinical and medical staff, but less from corporate staff, December 2025. Assurance report taken to ELT in April 2026, with good compliance for statutory and mandatory training. Workshops continue to be provided, along with coaching and mentoring. August 2026 Green Apprenticeship Levy report presented to the Finance and performance committee in September 2025 demonstrates that our spend has increased as well as the number of apprentices and types of apprenticeships, but there needs to be a focus widening the diversity pool of apprentices. Paper detailing action plan to improve diversity taken to ELT in November 2025. Communication plan is in place and work on the action plan May 2026. Annual report being taken to the Strategy and Culture Committee in September 2026 Green 2nd line: Mandatory and statutory training compliance reported monthly through IQPR, demonstrates 92% compliance overall with improvement required in some specific areas such as Resus, October 2025. MAST compliance stable from November 2025 to August 2026 Green	
Managers training programme, prioritising bands 6-8a- two day programme including policies and softer skills such as supporting staff to speak up and holding difficult conversations	1st line: 2 cohorts underway with feedback / evaluation undertaken after each training day. Positive feedback received from participants, December 2026. Cohorts booked throughout 2026/27, March 2026. Positive feedback received from ongoing delivery of managers training programme May 2026. Delivery continues – August 2026 Green	
Behaviour framework and implementation including embedding into 1:1's, appraisals, team charters, interview processes	1st line: Data related to number of appraisals completed is reported monthly in the IQPR, demonstrates the average compliance rate is 81% against the 90% target, February 2026. Completion rates continue to be monitored through IQPRs with focus on those over 3 months out of date. IQPR data for M12 2025/26 shows compliance at 83%	Executive Directors have a focus on working with their SLTs to improve the appraisal completion rates, reported monthly in their executive performance report. Discussed in IQPRs monthly with a focus for triumvirate leadership teams to improve completion rates.

	and an improving trajectory. Appraisals out of date by more than 3 months is decreasing, May 2026. Appraisal rates have improved to 86% Setember 2026 Amber Employee relations team weekly review of employee relations cases, demonstrates focus points for specific support and interventions required, October 2025. May 2026 – weekly review meetings continue, with thematics from cases triangulated with other data Green (see action 1) 2nd line: Organisational cultural assessment undertaken to be presented to the Board in November 2025, demonstrates that there are micro cultures and ongoing focus required to embed behavioural framework. Presented to Board in November, with ongoing work to support culture development (December 2025). Update on areas of consideration and next steps presented to Strategy and Culture Committee in March 2026 . V2 of the report will be presented to the Strategy and Culture committee in Q2 2026/27 and will compare to V1 Green	
Mechanisms in place for staff to provide feedback incl. Staff Survey, Quarterly People Pulse Surveys, Freedom to Speak Up Service, 'Tell Liz', 'Ask Abigail'	2nd line: 2024 Staff survey results published in March 2025 with a 57% response rate, demonstrate disabled staff have a less positive experience than non-disabled staff and staff do not always feel confident action will be taken if they speak up. 2025 staff survey results published in March 2026, with a 56% response rate and a small decline in some areas for speaking up, and increase in some areas, with focussed work underway to prioritise areas of decline. Update paper being taken to the Strategy and Culture Committee in September 2026 Green People Pulse Survey for Q2 was responded to by 14% of staff which demonstrated a decline in mood and motivation. People Pulse Survey for 2025/26 (up to January 2026) was responded to by 474 staff. In Q4 139 (10.7%) staff completed the People Pulse Survey. The Q4 results demonstrated an improvement in mood and motivation. Pulse survey is currently live for completion during April 2026. The Q1 People Pulse Survey results will be presented to the Strategy and Culture Committee in August 2026 Green 3rd line: FTSU Guardian report presented to the Board in July 2025 demonstrated that more staff are speaking up but some staff still wishing to stay anonymous due to concerns about the consequence. FTSU report and Raising concerns report presented to the Board in February 2026, with some staff still wishing to stay anonymous. Updated report presented to the Board in April 2026. Update presented to the Board in July 2026. Green	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Ongoing promotion and embedding of behaviour framework and values through workshops, staff survey action plans and team charters.	March 2026	Head of Leadership and OD	Completed Workshops delivered in October and November 2025 and January 2026. Will continue through 2026/27
2. Communication and engagement plan to encourage non-clinical staff to apply for Charity funded training to support their development	March 2026	Head of Leadership and OD	Completed

			Comms will continue through 2026/27
3. Communication and engagement plan to encourage a wider diversity of apprenticeship applicants	March 2026	Head of Leadership and OD	Completed Action plan presented to ELT November 2025 with ongoing work in place and a comms plan agreed Comms will continue through 2026/27
4. Link into to partner organisations to join/ support EDI networks	April 2027	Chief People Officer	Underway / on track, with discussions ongoing with Chief People Officers of partner organisations
5. Organisational culture review incl. associated programmes of work	September 2026	Chief People Officer	Completed
6. Staff survey detailed analysis to go to Board (via SCC)	September 2026	Chief People Officer	Completed
Links to Organisational Risk Register	133 (hard to recruit to roles)		

BAF008 - QUALITY

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27	Q3- 2026/27	
✓	✓		✓								

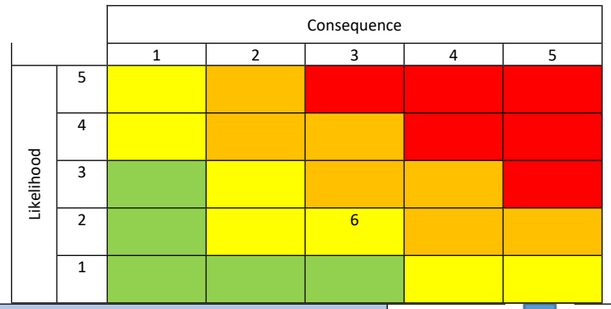
BAF	Risk: There is a risk that the Trust may be unable to consistently deliver high quality, safe care Caused by: Pressures on workforce capacity, increasing patient demand, variation in clinical practice, infrastructure limitations or less effective governance arrangements Resulting in: Patient harm, poor patient experience, regulatory action, financial impact and reputational damage

Responsible committee	Quality and safety committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief medical officer / Chief nursing officer	**Date Risk last reviewed:**	13 October 2026		
Risk Handler(s)	Deputy Chief nursing officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Board

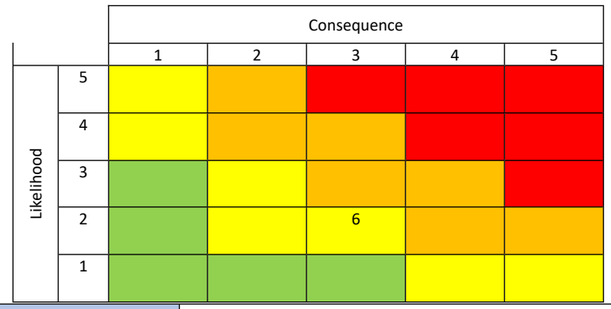
Inherent Score



Current Score



Target Score



Direction of travel since last review	
Target date	31 March 2027
Risk tolerance	Current risk score within risk appetite (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Quality impact assessments - to assess risk to quality and safety from cost improvement and productivity programme initiatives	1st line: Review of all QIA (completed by directorate lead) by CNO and CMO demonstrates no significant quality and safety concerns to date from CIP programme, February 2026, ongoing review of longer-term effects through IQPR Green Approved Quality and Equality Impact Assessment Policy Green 2nd line:	

	Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters. Green Incident reporting through Datix demonstrates no significant quality and safety issues because of cost improvement programme initiatives to date, February 2026, Green 3rd line: Friends and family test responses demonstrate that the recommendation rate was 94% (target 90%) as noted in M5 26/27 Green	
Incidents - consistent reporting of incidents with learning including thematic review supported by clinical governance framework. Patient safety incident response framework (PSIRF) approach in place and central incident reporting through the Learning from Patient Safety Events (LfPSE) platform	1st line: Summary incident reports collated and actively managed through directorates and groups reporting into Quality Committee Green Exec/ Board level weekly visibility rota within all areas of the Trust, October 2026 Green Trained PSIRF investigators and PSIRF followed Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters Green Monthly review of incident evaluation at formal governance groups including Executive Sub-committee for Quality demonstrates effectiveness of primary processes, Green Governance meeting surveillance including IPC, safeguarding, medical devices, health & safety to understand impact of incidents on patient safety and outcomes, Green Demonstration of learning through morbidity & mortality meetings, governance meetings, IQPR and the Clinical Learning Forum, Green 3rd line: Biannual quality review by the ICB raised no quality concerns, Q3 in 2025/26, Green Internal audit review of incident management during 25/26 concluded reasonable assurance, Green	Review PSIRF policy and ensure resource in place to maintain effective and timely management of incidents following completion of the working group addressing historical incidents
Complaints process - in line with national guidance and quality priority for 25/26. Process in place to hear patient voice and respond in a timely fashion	1st line: Summary complaint reports collated and actively managed through directorates and groups reporting into Executive sub-committee for Quality, Green 2nd line: Quarterly reports are submitted to Quality and safety sub-committee of Board Green Responsiveness to patient complaints is embedded within assurance on 2025/26 quality priorities, Green	

	Patient stories to Board, September 26, Green Annual Complaints and Claims Report to Trust Board, July 2026, Green 3rd line: Reporting demonstrates that there have not been any complaints escalated to the PHSO during 2024/25 and 2025/26 to date, September 2026, Green	
Speaking up mechanisms - including Direct to line manager, Freedom to Speak Up Guardian, Tell CNO, Ask CEO, Whistleblowing ensure opportunities for an open and honest culture in which quality of care can thrive	1st line Continuous and consistent utilisation of speak up mechanisms with good real-time feedback on response received by people speaking up reported to Quality & Safety Committee, Green 2nd line: Reporting to the Audit and risk committee demonstrates that there are numerous channels available for staff to speak up. Progress is being made to drive opportunities for improvement through key strategic priority 3: 'Enhance inclusive collaborative culture including behaviours framework and speaking up' reported monthly through IQPR Green 3rd line: Reports from FTSU guardian to Board demonstrate an increase in speak ups since the independent guardian has been in post. This is in contrast to the feedback from the staff survey which tells us that there is a decline in staff feeling safe to Speak Up, however this is being captured by ongoing action plans Green	Evidence of actions following staff survey address deficiencies in staff confidence to speak up needs to be addressed through behavioural framework initiatives and evidenced in regular reports
Clinical audit - plan to identify risks to quality, safety and effectiveness of care	1st line: Quality and Compliance Team regularly monitoring against audit and effectiveness standards. Green Monthly oversight meetings in place to track regulatory and governance review actions. Green 2nd line: Formal governance meetings including the Executive sub-committee for Quality in place with oversight of quality and safety matters Green Reporting on compliance with audit programme and NICE guidelines through ECQR demonstrates that where the Trust is not compliant, there are mitigations in place to manage the risks, February 2026, Green Board Seminar including focussed discussion on CQC preparedness, April 2026, Green 3rd line: Audit embedded in 2025/26 quality priorities and therefore reporting into Quality Account, Green	Constraints in IT resources limiting optimal data collection through digital systems need to be addressed.

BAF008 - QUALITY

Safe staffing procedures in place to ensure staffing fill rate does not fall below 98%.	1st line: Daily monitoring of staffing levels by HoNs demonstrates safe staffing levels. Staffing fill rate does not fall below 98% as of September 26, Green 2nd Line Formal governance meetings including the Executive sub-committee for Quality in place with oversight of quality and safety matters, Green Six monthly report to Board demonstrates procedures are in place and inpatient staffing levels are safe, and have been reviewed in line with cost improvement plans, January 2026, Green 3rd line: NHSE Oversight of safer staffing processes and compliance, Green	
Digital transformation - Archie EPR implementation included extensive clinical engagement which must continue through transition to Archie PAS and other digital transformation priority programmes	1st line: CNIO in post with clinical safety capability supporting maintenance of hazard log and clinical safety case, further Clinical Safety Officers (CSOs) trained and supporting this work. CCIO in place and supporting improvement in end user experience, Green 2nd line: Third party vendor provided independent clinical safety assessment for Archie EPR to ensure areas of non-compliance with DCB1060 highlighted prior to go live, remaining actions completed by Archie EPR Programme Team. Internal CSOs trained and collaborating to support further digital transformation including PAS supported with mentorship from the third-party vendor, Green	Funding constraint in ongoing support for the digital transformation programme including clinical safety for 26/27
Clinical Governance reporting framework established	1st line: Dedicated clinical governance staff time to ensure consistent recognition and evaluation of quality and safety metrics, Green 2nd line: Quality and safety sub-committee of Board and executive sub-committee for quality in place with oversight of quality and safety matters, November 2025, Green Reporting through revised Quality, Safety and (clinical) Risk infrastructure to regularly evaluate achievement against metrics and learning from triangulated data, Green 3rd line: Report from Well-led review received in July 26 and action plans based on recommendations being approved at ELT and Trust Board, Amber	
Staff Training – Designated leadership in clinical professional learning. Electronic and face to face training environments.	1st line: Line manager oversight of training compliance through ESR, Green 2nd line: MAST training compliance monitored and acted upon through Quality committee, Green	

	3rd line: Provider assurance framework includes oversight of training data, Green	
Clinical Risk Management – drives understanding and action on identified risk to quality and safety.	1st line: Inphase risk management system in place to manage risk, Green 2nd line: All clinical risks reviewed and new risks approved at the Executive sub-committee for Quality, Green IQPR, ECQR and local clinical governance meetings where risk evaluation takes place, Green 3rd line: Internal audit of risk management received reasonable assurance in 25/26, Green	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Evidence of actions following staff survey address deficiencies in staff confidence to speak up needs to be addressed through behavioural framework initiatives and evidenced in regular reports	31 March 2027	CPO, CNO, CMO	In progress / ongoing
2. Quality and Equality Impact Assessment Policy being revised to incorporate QIA, EIAs and ongoing monitoring / assurance	31 August 2026	CNO, COO, CMO, CIP Leads	Complete
3. Review PSIRF policy and ensure resource in place to maintain effective and timely management of incidents following completion of the working group addressing historical incidents	31 October 2026	CNO, Head of Safety & Patient Experience	In progress
4. Biannual Raising concerns paper identified a reduction in 'Tell CNO' enquiries which may be linked to lack of anonymity, to review and monitor for next paper	31 July 2026	CNO, Head of Safety & Patient Experience	Complete
5. Reconfiguration of nursing staff and review of the impact on quality once in place to include care of patients in outpatient environment	31 October 2026	CNO	Complete
6. Reflection on clinical governance structure and processes will be required on receipt of the Well-led review report.	31 September 2026	CNO, CMO	Complete
7. Senior leaders to dedicate time for visibility within services to enable learning, support and improvement.	31 September 2026	Executives & Senior Leaders	Complete

Links to Organisational Risk Register	16 (mental capacity act), 17 (staff may not speak up with concerns), 38 (environment on peanut ward), 117 (medical devices), 125 (mental health provision), 189 (sustainability of key services)

BAF009 - REGULATION

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27	Q3- 2026/27	
✓	✓	✓	✓	✓							

BAF

Risk description

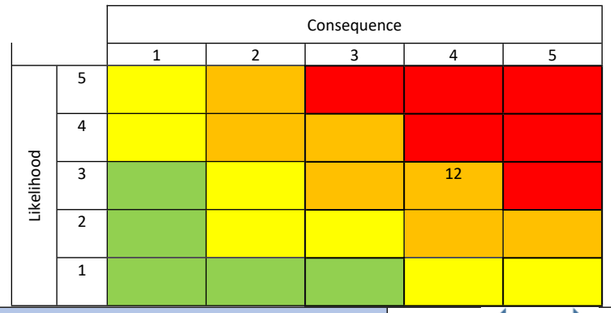
Risk:
There is a risk that the Trust may not be able to meet its regulatory requirements
Caused by:
Scale; cost improvement plans; corporate savings; turnover at Board level; non-compliance; leadership capacity; national changes to requirements
Resulting in:
Damage to reputation; non-removal of additional licence conditions; regulatory intervention

Responsible committee	Audit and Risk committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Chief executive officer	**Date Risk last reviewed:**	6 October 2026		
Risk Handler(s)	Company secretary	**Date Risk last formally discussed:**	9 July 2026	**Group**	Trust Board

Inherent Score



Current Score



Target Score



Direction of travel since last review	⟷	**Target date**	July 2026
		Risk tolerance	Current risk score outside of risk appetite (higher) (minimal)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Key Trust policies in place aligned to statutory and regulatory requirements	1st line: Reporting to the ECQR demonstrates that a revised 'policy for policies' is in place and has been disseminated to staff. The revised policy for policies seeks to ensure consistency for policy management across the Trust, however further assurance is required to demonstrate improvements with policy management, July 2025, Amber (see action 1) Reporting to the ECQR demonstrates that a robust process is in place to ensure that policy owners are made aware when policies are expiring incl the deadline and process for updating them, December 2025, Green Oversight dashboard in place as of Q4 2025/6. Policies at 92% compliance as of June 30 2026, Green	Assurance that the 'policy for policies' has been embedded and driving improvements in policy management Assurance that progress is being made in updating out of date policies or taking them out of circulation if they are deemed to be duplicative/ no longer required

	2nd line: Reporting to the ECQR on out of date policies demonstrates that of 239 active policies, 19 are out of date which is an decrease since the last review. No key corporate policies are out of date, June 2026, Green (see action 2) 3rd line: Internal Audit reported that 28 actions arising in 2025/26 had been implemented, including all high-priority actions, with remaining actions monitored through Audit & Risk Committee. June 2026, Green	
Governing documents in place including Trust Constitution, Scheme of delegation and reservation of powers, Standing financial instructions aligned to statutory and regulatory requirements	1st line: Reporting to the Audit and risk committee regarding compliance demonstrates no known breaches since Q4 2024/25, June 2026, Green 2nd line: Approved Annual Governance Statement conclusion for 2025/26 demonstrates no significant control issues. This is aligned to the Head of Internal Audit opinion, June 2026, G Green 3rd line: Head of Internal Audit Opinion 2025/26 concluded that there are areas with a generally sound system of internal control designed to meet the Trust's objectives and that controls are generally being applied consistently, although some improvements can be made, June 2026, Green The Trust received confirmation in March 2026 that its additional licence conditions have been removed due to the Trust's work on its strategy and strategic partnership and the strong relationship between the Board and Council of Governors, March 2026, Green	
Annual Provider Capability Assessment demonstrating Board awareness of gaps against key lines of enquiry from the Insightful Provider Board guidance	1st line: Provider capability assessment undertaken by the Board demonstrates a confirmed rating for quality of care and people and culture and a partially confirmed rating for other areas. The submission demonstrated action being taken to address gaps. An update on the progress against the gaps was taken to Audit & Risk committee in June 2026. June 2026, Green (see action 5) 3rd line: Review of Provider capability assessment undertaken by NHSE and QVH received a rating of Amber/Green which is aligned to the Trust's own assessment, March 2026, Green	Review of progress against actions to address gaps- scheduled for June 2026
Code of Governance for NHS Provider trusts	2nd line: Annual review of compliance against the Code of Governance for NHS provider trusts to Board demonstrates one area of non-compliance during 2025/26, related to NED pay. This is compared to multiple areas of compliance being reported in previous years. March 2026, Green	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Review of effectiveness of 'policy for policies'	~~July 2026~~ September 2026	CS, executive team	On track

BAF009 - REGULATION

2. Continued oversight of management of out of date policies incl. priority areas	Ongoing	Policy owners	On track
3. Develop Governance handbook to support staff across organisation	March 2026	CS	First draft complete
4. Assurance to Audit and risk committee about compliance with governing documents	March 2026	CS, CFO	Completed
5. Review of progress against actions to address gaps within Provider capability assessment	June 2026	CEO, CS	Completed – June Audit & RIsk committee update paper
Links to Organisational Risk Register			

BAF010 – SUSTAINABILITY AND STRATEGY

KSO1	KSO2	KSO3	KSO4	KSO5	Overall Assurance Rating (RAG)	Q3- 2025/26	Q4- 2025/26	Q1- 2026/27	Q2- 2026/27	Q3- 2026/27	
✓	✓	✓	✓	✓							

BAF	**Risk description** Risk: There is a risk that the Trust will not secure long-term sustainability Caused by: Inability to progress the strategic partnership; Potential delays in progressing the partnership; Challenges with progression of partnership implementation and associated decision making; a potential breakdown in relationship between the Board and the Council of Governors; leadership capacity and resilience challenges; changes to the commissioning of services; changes to service specifications; staff morale; time constraints Resulting in: Sustainability challenges for patient services/ site; priority shift of QVH Strategy 2025-2030; regulatory intervention; reputational damage; non-delivery of recurrent annual financial, productivity and efficiency savings

Responsible committee	Strategy and Culture Committee	**Date Risk Added:**	13 November 2025		
Principal Exec – Risk Owner	Acting Chief Strategy Officer	**Date Risk last reviewed:**	25 September 2026		
Risk Handler(s)	Acting Chief Strategy Officer	**Date Risk last formally discussed:**	9 July 2026	**Group**	Board of Directors

Inherent Score



Current Score



Target Score



Direction of travel since last review		**Target date**	April 2027
		Risk tolerance	Current risk score outside of risk appetite (higher) (open)

Controls (what are we doing about risk)	Assurances and RAG rating (how do we know if it's working)	Gaps in assurance (what additional assurance is needed)
Engagement with strategic partners- regarding partnership arrangements and implementation	1st line: Partnership steering group (internal established and considers engagement with partners, March 2026, Green Reporting on engagement with partners to Strategy and culture committee demonstrates that engagement is effective and that progress is being made against the plan, February 2026, Green 3rd line:	Joint Transformation committee across partners to be considered after senior leadership appointments in October 2026.

	Weekly partnership working group established between partners, January 2026, Green Regular meetings established between Chairs and CEOs, March 2026, Green Lead Governor visit to RSFT May 2026, Green Further walk in workshop planned for staff and volunteers June 2026, Green	
Engagement with key stakeholder's incl. NHSE and ICB- regarding potential partnership arrangements and option appraisal process incl. staff, patients, members, Council of Governors, primary care partners	1st line: Reporting to the Strategy and Culture committee demonstrates wide ranging engagement undertaken internally and externally from September 2025, Green Communication and engagement plan post Board approval has been agreed between partners from August 2026, Green Shared lines of communication for the phase Aug 26 – March 27 is in development across all three partners, Green	Stakeholder analysis across all partners to be completed
Timeline - Agreed timeline in place to keep track of key milestones incl. Chair and CEO in place by September 2026 and key decision-making points	1st line: Progress continues across programme workstreams, with commencement of workstreams and finance reviews from NHSE and RSFT CFO completed, Green 2nd line: ASPH/RSFT agreed for QVH to join the expanded group (following on QVH decision in December 2025). Green ASPH/RSFT/QVH signed MoU in July 2026. Green ASPH/RSFT/QVH appointments approved, Group Chair and Group CEO starting October. Green 3rd line: Continued engagement with NHSE demonstrates alignment with key timelines, May 2026, Green QVH well-led review now completed and action plan being developed, Green	
Governance and oversight - Oversight by the Strategy and culture committee (SCC) and Board including input from Council of Governors and Strategic assurance group. Strategic direction by NHSE and ICB	2nd line: Ad-hoc Strategic Assurance Group (SAG) made of up internal key stakeholders in place to ensure critical decision making is appropriate and transparent, May 2026, Green 3rd line: Monthly QVH internal Partnership Steering Group in place from March 2026, Green Weekly Partnership working group between QVH and RSFT/ASPH in place from March 2026, Green	
Partnership implementation plan- incl. six key workstreams: Programme management, Corporate governance, Communication and engagement, Leadership and culture, Financial and planning alignment 2026/27, Clinical and corporate alignment	1st line: Reporting to Strategy and culture committee demonstrates that implementation plan is in place and progressing from February 2026, Green Early benefits realisation shared with Finance and performance committee in September 2026. Green Governance structure for first 6 months (From October 2026) has been defined, Green	Proposed governance structure for partnership April 27 onwards not yet defined Further development of targeted benefits realisation to be shared at the next FPC meeting Develop a detailed programme plan for the next 3-6 months Well-led development plan to be completed and agreed

	2nd line: Six key workstreams have assigned executive senior responsible officers and risks have been identified with mitigations, March 2026, Green 3rd line: Financial governance review of QVH undertaken by NHSE demonstrates no concerns. Recommendations will be monitored by the Partnership steering group, March 2026, Green Review of financial documents undertaken by partners Chief finance officer demonstrates no significant concerns, March 2026, Green Well-led review collated and action plan in development and completed in October 2026, Amber	

Actions	**Timescale**	**Lead**	**Status** (complete, on track, off track, not yet started)
1. Continued shared engagement including internal and external stakeholders	Ongoing until implementation	DCSO	On track
2. Governance arrangements in place to support December decision making – including Board to Board meetings	November 2025	AJ/ LM	Complete
3. Development of FAQ document for staff and key stakeholders	December 2026	DCSO	Complete with ongoing updates as they arise
4. Development of transition and implementation (incl. Governance) plan for partnership	March 2026	CEO, DCSO, CS	Complete with ongoing updates as they arise
5. Timeline for transition planning needs to be agreed between partners	March 2026	Chair, CEO	Complete- agreed to work in parallel
6. Communication and engagement plan needs to be agreed between partners	March 2026	DCSO	Complete with ongoing updates as they arise
7. RSFT/ASPH Stakeholder analysis to be completed	~~July 2026~~ November 2026	Acting CSO	On track
8. Arrangements to be made for QVH to join partners Transformation committee	~~August 2026~~ November 2026	Acting CSO	On track
9. QVH well led review of leadership and governance	July 2026	CS	Complete
10. Benefits realisation for partnership draft to be shared with FPC	~~August 2026~~ September 2026	Acting CSO	Complete- shared with FPC
11. Contingency planning in the event of a delay in implementing the partnership	July 2026	Board	Complete
12. Contingency planning in the event of a delay in the CoG decision in September around senior leadership	October 2026	CSO/CoSec	Complete- appointments approved at CoG
13. Board sign off of partnership MoU across all three Trusts	July 2026	Board	Complete
14. Finalise well-led review action plan based on recommendations, to be signed off by Board	November 2026	CoSec	On track
15. Develop a detailed programme plan for the next 3-6 months	October 2026	CSO	On track

Links to Organisational Risk Register	132 (delivery of QVH Strategy 2025-2030), 189 (long term sustainability of key services), 208 (shared chair and ceo timeline), 223 (leadership capacity during partnership transformation), 224 (staff uncertainty and resistance to change), 225 (reduced leadership presence and visibility across QVH), 226 (finance and benefits), 234 (stakeholder confidence)

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026	**Agenda reference:**	**109-26**		
Report title:	Thirlwall Inquiry				
Sponsor:	Liz Blackburn, Acting Chief Nursing Officer				
Author:	Liz Blackburn, Acting Chief Nursing Officer				
Appendices:	Immediate Actions and evidence required to demonstrate the Trust's response				
Executive summary					
Purpose of report:	To present the Trust response to the findings and recommendations arising from the Thirlwall Inquiry.				
Summary of key issues	• The Thirlwall Inquiry identified significant failings in patient safety, safeguarding, governance, organisational culture, Duty of Candour and risk management. • NHS England has requested organisations review the Inquiry findings and implement actions to strengthen assurance and oversight. • The Trust has undertaken a review of existing arrangements and identified opportunities to strengthen consistency, learning and governance. • The recommended action plan arising from the inquiry has been interpreted in the context of the Trust and delivery of this will be monitored through the Quality and Safety Committee.				
Recommendation:	The Board is asked to: • **Note** the findings and recommendations arising from the Thirlwall Inquiry.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	KSO2:	**KSO3:**	KSO4:	KSO5:
	To deliver outstanding care	*To innovate and improve*	***To be an excellent employer***	*To deliver sustainable services*	*To collaborate with others*
Implications					
Board assurance framework:	KSO1 and KSO3 – Quality and safety, safeguarding and organisational culture.				
Organisational risk register:	Supports assurance against risks relating to patient safety, quality governance, safeguarding and organisational culture.				
Regulation:	Compliance with NHS England requirements arising from the Thirlwall Inquiry and NHS safeguarding and patient safety expectations.				
Legal:	Statutory safeguarding responsibilities, the Duty of Candour and wider governance obligations relating to patient safety and quality oversight.				
Resources:	Actions will be delivered through existing governance, safeguarding and quality improvement arrangements.				
Assurance route					
Previously considered by:					
	Date:		Decision:		
Next steps:					

Thirlwall Inquiry – QVH Response

1. Background

The publication of the Thirlwall Inquiry has provided a significant opportunity for NHS organisations to reflect on the circumstances that enabled serious failings in patient care to occur and continue unchecked over an extended period. It is an important reminder that patient safety depends not only on the actions of individual clinicians, but on the culture, leadership and decision-making of the organisations in which they work.

The Inquiry identified weaknesses in patient safety systems, safeguarding arrangements, organisational culture, governance and the escalation of concerns, and highlighted the importance of ensuring that staff are supported to raise issues and challenge practice. It also reinforces the consequences when professional judgement, safety signals and staff feedback are not listened to or acted upon promptly.

Following publication of the Inquiry's findings, NHS England requested that NHS organisations review the recommendations, assess existing arrangements and identify any further actions required. Whilst the events considered by the Inquiry occurred within a specific organisational context, the themes and lessons identified have relevance across the NHS and provide an opportunity for organisations to test whether current systems and processes would support the timely identification, escalation and management of similar concerns should they arise.

2. The Trust Response

Following publication of the Inquiry and the subsequent NHS England requirements, the Trust has undertaken a review of existing arrangements relating to patient safety, safeguarding, governance, organisational culture and risk management. This review has been informed by the key findings and recommendations arising from the Inquiry, together with an assessment of current controls, sources of assurance and areas requiring further development.

Whilst the review identified a number of areas where robust arrangements are already in place, opportunity was identified to strengthen consistency, enhance collective learning and reinforce the importance of early escalation, professional challenge and organisational transparency.

The actions requested by NHS England, together with the Trust’s proposed review will be delivered through a combination of partnership-wide initiatives and organisation-specific actions and will be monitored through established governance arrangements.

3. Assessment

3.1. Patient Safety and Safeguarding – Put Patients First

The strongest theme throughout the report is the failure to place patient safety first. Concerns that babies may have been harmed should have triggered immediate safeguarding action. Instead, concerns were repeatedly questioned, minimised or deferred while alternative explanations were sought. The Inquiry concludes that safeguarding principles were not understood or applied effectively.

Patient safety must always take precedence over any operational pressures, reputation, performance targets or organisational discomfort. When difficult decisions arise, all organisations should be putting patients first.
The findings of the Inquiry highlight the opportunity to strengthen collective assurance and ensure a consistent understanding of safeguarding responsibilities.

The Trust will ensure that safeguarding training is consistently provided to employees, workers, volunteers, Board members and Non-Executive Directors at a level appropriate to their role and responsibilities. This will include strengthening awareness of the recognition, escalation and management of concerns relating to deliberate harm, including implementation of the Suspicion of Deliberate Harm Protocol where appropriate.

The Trust will also work to ensure that employment arrangements, organisational policies and workforce processes clearly articulate safeguarding responsibilities and are compliant with relevant safeguarding guidance.

3.2. Leadership and Governance - Use Governance Processes Properly

The Inquiry found that executive leaders failed to respond appropriately to escalating concerns raised by clinicians. Information was not consistently shared with Boards, regulators, commissioners or safeguarding agencies and governance arrangements did not provide effective challenge or oversight of emerging risks.

In line with these findings, it is recognised that robust governance arrangements, including clear policies, effective incident reporting systems, safeguarding processes and Freedom to Speak Up mechanisms, are essential components of safe patient care. These arrangements must be actively utilised by all leaders and managers to support timely escalation, effective risk management and informed decision-making. Managers are expected to seek appropriate advice, respond proactively to concerns raised by staff, and ensure that professional challenge is welcomed and acted upon, thereby fostering a culture of openness, transparency and continuous learning.

The Thirlwall Inquiry reinforces the importance of avoiding a culture of self-assurance in which positive performance messages outweigh scrutiny of areas of concern. Board discussions should provide equal emphasis to understanding risks, challenging assumptions, hearing dissenting views and seeking evidence of effectiveness, thereby ensuring that assurance reflects the reality of frontline practice rather than solely reported compliance.

The Trust will continue to strengthen mechanisms that provide executive leaders and Boards with visibility of emerging risks and assurance that patient safety and safeguarding concerns are identified, escalated and acted upon at the earliest opportunity. All governance processes must support transparency, effective decision-making and appropriate escalation, ensuring that patient safety remains the primary consideration where concerns are identified.

3.3. Culture – Listen and Escalate

The Inquiry identified an organisational culture in which the concerns of experienced clinicians were not given sufficient weight. Rather than supporting professional challenge, the organisation increasingly viewed those raising concerns as a problem requiring management. This created barriers to escalation and delayed appropriate investigation.

Concerns raised by staff, patients or families should never be dismissed or minimised, but should be listened to, given careful consideration and a formal review. It is important that any repeated concerns, unusual clinical outcomes, or patterns that do not feel right are given the same scrutiny and are not ignored.

A culture of good psychological safety ensures that every member of staff feels able to speak up without fear of criticism or retribution. A healthy culture welcomes challenge and values professional curiosity.

The Trust recognises that an open and transparent culture is essential to the delivery of safe care. Professional curiosity, constructive challenge and speaking up arrangements are actively supported throughout the organisation to ensure concerns are heard, objectively considered and responded to appropriately.

Existing Freedom to Speak Up arrangements, workforce engagement mechanisms and leadership development programmes provide assurance in this area, however, the findings of the Inquiry reinforce the need for continual focus on psychological safety and staff confidence to raise concerns.

3.4. Duty of Candour - Be Open, Honest and Accountable

The Inquiry identified significant failures in openness with families, coroners and external agencies. Parents were not informed about concerns regarding their babies' deaths and collapses for many months and, in some instances, years. The report concluded that organisational responses frequently prioritised reputational management over transparency.

This reinforces that good leadership requires transparency, particularly when things may have gone wrong. Decisions should be documented, concerns investigated fairly, and learning shared openly. All managers are to discuss these principles within their teams and consider what further improvements can be made locally to strengthen their safety culture, making patient safety the responsibility of every one of us.

Patients, families and carers have a right to timely and accurate information when concerns arise and should be supported appropriately throughout investigations, reviews and responses to these concerns.

The Trust is committed to the principles of Duty of Candour and will continue to strengthen assurance regarding compliance, family engagement, external reporting and organisational transparency. Learning arising from incidents, investigations and reviews will be shared openly to support improvement and maintain public confidence.

3.5. Risk Management – Identify Problems Early

The Inquiry identified significant weaknesses in risk management processes. Risks were not recognised and escalated promptly, patterns were not effectively identified and concerns were not always framed around the risk of patient harm. As a result, opportunities to intervene and prevent harm were missed.

The Trust must be confident that information from incidents, complaints, claims, safeguarding concerns, Freedom to Speak Up reports, staff surveys and workforce data is routinely reviewed and triangulated to identify emerging themes and risks.

The Trust acknowledges the importance of maintaining robust risk management arrangements that prioritise patient safety and support the early identification,

escalation and mitigation of emerging risks. The Inquiry further highlights the importance of triangulating information from incidents, complaints, safeguarding concerns, workforce intelligence and speaking up arrangements to identify potential patterns and themes.

The Trust will continue to strengthen risk management through triangulation of received intelligence, particular emphasis will be placed on ensuring that patient safety considerations remain paramount within decision-making and governance processes.

4. Risks

Failure to implement the actions arising from the Inquiry may result in weaknesses in the identification, escalation and management of patient safety and safeguarding concerns, reducing the ability of the Trust to respond proactively to emerging risks. This may increase the risk of avoidable harm, weaken organisational learning and reduce confidence in organisational safety systems.

Failure to maintain an open and transparent culture may adversely affect staff confidence to speak up, challenge decisions and raise concerns. Weaknesses in governance and oversight arrangements may also reduce the effectiveness of scrutiny and decision-making by Boards and senior leaders.

Failure to comply with safeguarding responsibilities, Duty of Candour requirements and NHS England expectations may result in increased regulatory scrutiny, reputational damage and a loss of confidence amongst patients, families, staff, partner organisations and regulators.

These risks will be monitored through established governance arrangements and regular assurance reporting against the agreed action plan.

5. Conclusion

The findings of the Thirlwall Inquiry provide an important reminder of the consequences of failing to recognise, escalate and respond appropriately to patient safety concerns. The Trust review has identified substantial assurance across existing safeguarding, governance, cultural and risk management arrangements whilst also recognising opportunities to strengthen consistency, organisational learning and oversight.
The most important lesson from the Thirlwall Inquiry is not about looking for blame. It is about creating an organisation where concerns are taken seriously, professional judgement is respected, and patient safety is everyone's responsibility.
The immediate action plan arising from the Inquiry and listed in the appendix provides a structured response to the issues highlighted by the Inquiry which will be adopted across all Trusts within the Group. The plan will support organisations in ensuring lessons are embedded within existing systems and processes. Progress against the plan will be monitored through the Trust’s governance arrangements and future assurance reports will be provided to demonstrate implementation and impact.

6. Recommendations

The Board is asked to:

- **Note** the findings and recommendations arising from the Thirlwall Inquiry.

Appendix One – Immediate Actions and evidence required to demonstrate the Trust's response

Action	Lead	Due Date	Evidence / Output
Present the Thirlwall Report at the next public Trust Board meeting.	Chief Nursing Officer	November 2026	Board paper, discussion and minutes evidencing assurance and actions identified. Progress updates reported through Quality and Safety Committee.
Review organisational culture to ensure staff and Board members feel empowered to speak up, challenge concerns and escalate issues without fear.	Chief Nursing Officer / Chief People Officer/ Freedom to Speak Up Guardian	December 2026	Culture review and assurance report. Triangulation of the Trust's Staff Survey, FTSU, grievance, disciplinary and incident reporting data. Evidence of improvements monitored through the Quality and Safety Committee and Board assurance reporting.
Communicate SUDIC requirements to all relevant neonatal, paediatric, safeguarding, medical and nursing staff.	Chief Nursing Officer / Chief Medical Officer / Head of Safeguarding	28 September 2026 (for all Trusts with a neonatal unit)	Evidence of communication and staff acknowledgement. Inclusion in safeguarding mandatory training with compliance reported to Board.
Review local policies, guidance and training to ensure compliance with the SUDIC protocol and confirm staff understand reporting and escalation requirements.	Head of Safeguarding	December 2026	All policies and guidance reviewed and ratified. Case note audit of compliance with SUDIC requirements. Training record compliance and audit findings reported to Quality and Safety Committee.

Undertake a gap analysis against the National Bereavement Care Pathway and implement improvements to bereavement care for families experiencing stillbirth or neonatal death.	Chief Nursing Officer	January 2027	Gap analysis against pathway and improvement plan. Evidence of family involvement in all bereavement care.
Complete a review of neonatal insulin storage, security and access arrangements against GIRFT guidance.	Chief Pharmacist	December 2026	Not applicable.
Install CCTV monitoring of neonatal insulin storage areas (fridges, cupboards and storage units) with recordings retained for a minimum of 28 days.	Director of Estates & Facilities	30 November 2026	Not directly applicable. Review of CCTV arrangements throughout the Trust. Compliance with regulatory standards (eg Data Protection Act 2018 & UK GDPR)
Ensure all neonatal insulin storage arrangements comply with GIRFT requirements, including enhanced access controls.	Chief Pharmacist / Director of Estates & Facilities	31 March 2027	Not applicable.
Review and achieve safeguarding training compliance for all staff and Board members at the appropriate level.	Head of Safeguarding / Learning & Development Lead	January 2027	Training compliance monitored monthly with target compliance being achieved. Exception reporting at the Strategic safeguarding Group.
Confirm all staff understand safeguarding reporting and escalation routes and know who to contact for advice and support.	Head of Safeguarding	January 2027	Coordination and triangulation of staff communications, training records and audit results. Timely incident reviews and escalation.

Provide ongoing assurance that safeguarding of babies and children is appropriately prioritised through governance, quality and risk management arrangements.	Chief Nursing Officer	Quarterly	Safeguarding assurance reports to Quality and Safety Committee and Board. Annual safeguarding report to Trust Board.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026		**Agenda reference:**	**110-26**	
Report title:	Lord Mann Review – adoption of the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism and the Government's non-statutory working definition of anti-Muslim hostility				
Sponsor:	Helen Edmunds, Chief People Officer				
Author:	Helen Edmunds, Chief People Officer				
Appendices:	None				
Executive summary					
Purpose of report:	To seek approval of adoption of the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism and the Government's non-statutory working definition of anti-Muslim hostility as part of the Lord Mann review and recommendations.				
Summary of key issues	• The Lord Mann Review made a number of recommendations aimed at strengthening the NHS response to antisemitism, anti-Muslim hostility and wider forms of racism and discrimination. • Adoption of the IHRA definition and anti-Muslim hostility definition would align the Trusts with the UK Government, DHSC and NHS England • ASPH, QVH and RSFT have worked collaboratively to consider the recommendations and develop a consistent approach to implementation. • This paper presents the proposed definitions and principles for adoption and seeks the Committee's recommendation to the Board of Directors for approval.				
Recommendation:	The Board are asked to: • **Note** the collaborative approach taken by ASPH, QVH and RSFT in considering the implementation of recommendations from the Lord Mann Review. • **Approve** the adoption of the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism, and the Government's non-statutory working definition of anti-Muslim hostility.				
Action required	**Approval**	Information	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	KSO1:	KSO2:	**KSO3:**	KSO4:	KSO5:
	To deliver outstanding care	*To innovate and improve*	***To be an excellent employer***	*To deliver sustainable services*	*To collaborate with others*
Implications					
Board assurance framework:	None				
Corporate risk register:	None				
Regulation:	None				
Legal:	The proposal supports the Trust's obligations under the Equality Act 2010 and Public Sector Equality Duty by promoting good relations and helping to eliminate discrimination.				
Resources:	None				
Assurance route					
Previously considered by:	Strategy and Culture Committee				
	Date:	29/10/2026	Decision:	Approve the paper being presented to the Board	
Next steps:	Subject to Board approval, adoption of the detailed definitions				

Lord Mann Review – adoption of the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism and the Government's non-statutory working definition of anti-Muslim hostility

1. Background

In June 2026, Lord Mann published his independent review into antisemitism within the NHS. The review examined experiences of antisemitism and identified opportunities to strengthen organisational culture, leadership, education, incident reporting and governance arrangements. The review also highlighted the importance of addressing anti-Muslim hostility and wider forms of racism and discrimination.

The recommendations included consideration of the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism and the Government's non-statutory working definition of anti-Muslim hostility.

The IHRA Working Definition of Antisemitism was adopted in 2016 as a non-legally binding framework to support organisations in recognising and responding to antisemitism.

The UK Government adopted the definition in 2016 and the Secretary of State, in October 2025, reaffirmed the Department of Health and Social Care's (DHSC) commitment to it. At that time, the Secretary of State asked that other DHSC Executive Agencies and Arms-Length Bodies (ALBs) adopt it. NHS England wrote to NHS Trusts in October 2025 to confirm they were formally and actively adopting the definition and strongly encouraged all NHS organisations to do likewise as part of wider efforts to tackle racism, antisemitism and other forms of hatred across the health service.

To support this, the UK Government also announced upcoming updates to mandatory equality, diversity and inclusion training for all NHS staff to include antiracism and antisemitism.

2. Partnership Approach

ASPH, QVH and RSFT have adopted a collaborative approach to considering the recommendations arising from the Lord Mann Review, seeking where appropriate to achieve consistency in implementation across the three organisations.

This collaborative work has enabled the organisations to share learning, consider implementation approaches and identify opportunities for alignment whilst recognising that each Board remains responsible for its own statutory decision-making and governance responsibilities.

A consistent approach across ASPH, QVH and RSFT supports shared organisational values, provides clarity for staff working across organisational boundaries and enables the organisations to share learning and best practice. The organisations have agreed to continue working collaboratively to support implementation and share learning as national guidance develops.

The group will ensure that Board and executive leadership development arrangements reflect national requirements arising from the Lord Mann Review, including antisemitism awareness training for Chairs and Chief Executives (to be arranged once

training has been released by NHS England), and support continued leadership accountability in promoting an inclusive organisational culture.

3. Proposed Definitions for Adoption

International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism

NHSE England and the Lord Mann review recommended that NHS organisations adopt the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism.

The definition states:

"Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."

The definition is intended to support organisations in recognising, understanding and responding appropriately to antisemitic behaviour and incidents.

Adoption of the definition would provide a recognised framework to support staff, managers and leaders when considering concerns relating to antisemitism.

Government Non-Statutory Working Definition of Anti-Muslim Hostility

NHS England and the Lord Mann review also recommended adoption of the Government's non-statutory working definition of anti-Muslim hostility.

The definition states:

"Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts, including acts of violence, vandalism, harassment or intimidation, whether physical, verbal, written or electronically communicated, that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

It is engaging in unlawful discrimination where the relevant conduct, including the creation or use of practices and biases within institutions, is intended to disadvantage Muslims in public and economic life."

The definition supports organisations in recognising and understanding anti-Muslim hostility and in ensuring concerns are appropriately identified, reported and addressed.

The adoption of both definitions reflects a balanced approach to tackling prejudice and discrimination and supports wider organisational equality, diversity and inclusion objectives.

The proposed adoption of these definitions does not diminish the importance of addressing other forms of racism, discrimination, harassment or hate-related behaviour.

4. Legal and Equality Considerations

In considering the recommendations arising from the Lord Mann review, QVH obtained independent legal advice regarding the proposed adoption of the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism and the Government's non-statutory working definition of anti-Muslim hostility.

The advice considered relevant equality, employment and human rights considerations and concluded that adoption of the proposed definitions, alongside clear organisational commitments to equality, inclusion and lawful freedom of expression, represents a balanced and proportionate approach to implementation.

The proposed approach supports the organisations' obligations under the Equality Act 2010 and aligns with wider NHS expectations regarding the elimination of discrimination, advancement of equality of opportunity and fostering good relations between different groups.

The adoption of the definitions does not create new legal rights, offences or disciplinary standards. Rather, they provide a framework to support the identification and understanding of antisemitism and anti-Muslim hostility within existing organisational and legal frameworks.

The trusts remain committed to addressing all forms of racism, discrimination, bullying, harassment and hate-related behaviour.

5. Implementation

Subject to approval through individual governance arrangements, implementation activities will include:

- Reviewing relevant workforce, equality and inclusion policies, being clear that all forms of discrimination, racism and hate are unacceptable.
- Updating supporting guidance and organisational procedures where appropriate.
- Communicating the definitions and associated expectations to staff.
- Engaging with staff networks and equality groups.
- Incorporating the definitions within relevant leadership and management development activities.
- Aligning implementation with wider equality, diversity and inclusion programmes.
- Monitoring progress through existing governance and assurance arrangements.

The three trusts will continue to share learning and best practice to support effective and proportionate implementation of the recommendations.

6. Risks

Failure to implement the recommendations may result in:

- Reduced alignment with national NHS expectations.
- Inconsistent organisational responses to incidents involving antisemitism and anti-Muslim hostility.
- Missed opportunities to strengthen organisational culture and staff experience.
- Reputational risks for the organisations.

These risks will be mitigated through robust governance arrangements, clear communication, staff engagement and ongoing monitoring.

7. Recommendations

The Board are asked to:

- **Note** the collaborative approach taken by ASPH, QVH and RSFT in considering the implementation of recommendations from the Lord Mann Review.
- **Approve** the adoption of the International Holocaust Remembrance Alliance (IHRA) Working Definition of Antisemitism, and the Government's non-statutory working definition of anti-Muslim hostility.

Report cover-page					
References					
Meeting title:	Board of Directors				
Meeting date:	12/11/2026		**Agenda reference:**	**111-26**	
Report title:	Revision of the Reservation of Powers and Scheme of Delegation				
Sponsor:	Jamie O'Callaghan, interim Company secretary Ross Dunworth, interim Chief finance officer				
Author:	Jamie O'Callaghan, interim Company secretary Jonathan Wharton, deputy Chief finance officer				
Appendices:	Appendix one- Reservation of powers and Scheme of delegation				
Executive summary					
Purpose of report:	To inform the Board of amendments to the Reservation of Powers and Scheme of Delegation, which were reviewed by the Audit & Risk Committee and approved by the Board of Directors via written resolution on 16 October 2026.				
Summary of key issues	The Reservation of Powers and Scheme of Delegation has been revised to reflect the introduction of the Group Chief Executive Officer and Managing Director roles, ensuring delegated authorities and accountabilities remain aligned with the Trust's current leadership structure. The proposed amendments were reviewed by the Audit & Risk Committee and approved by the Board of Directors via written resolution on 16 October 2026. A tracked changes version of the document is attached for information and transparency.				
Recommendation:	The Board of Directors is asked to: • **Note** the amendments made to the Reservation of Powers and Scheme of Delegation. • **Note** that the revised document was approved by the Board via written resolution on 16 October 2026, following review by the Audit & Risk Committee.				
Action required	Approval	**Information**	Discussion	Assurance	Review
Link to key strategic objectives (KSOs):	**KSO1:**	**KSO2:**	**KSO3:**	**KSO4:**	**KSO5:**
	Outstanding patient experience	***World-class clinical services***	***Operational excellence***	***Financial sustainability***	***Organisational excellence***
Implications					
Board assurance framework:	Supports delivery of the Trust's governance and compliance objectives.				
Organisational risk register:	Supports clear accountability and delegated authority.				
Regulation:	Trust Constitution, Standing Orders and Standing Financial Instructions.				
Legal:	Supports compliance with the Trust's governance framework.				
Resources:	None				
Assurance route					
Previously considered by:	Audit & Risk Committee & Board via written resolution				
	Date:	Oct 26	Decision:	Recommend/ Approve	
Next steps:					

Revision of the Reservation of Powers and Scheme of Delegation

1. Introduction

The Reservation of Powers and Scheme of Delegation are key components of the Trust's governance framework, setting out those matters reserved to the Board of Directors and those delegated to committees and officers of the Trust.

Following the appointment of the Group Chief Executive Officer and the introduction of the Managing Director role at Queen Victoria Hospital NHS Foundation Trust, a review of the document was undertaken to ensure that it remained aligned with the Trust's organisational and leadership arrangements.

The proposed revisions were reviewed by the Audit & Risk Committee and subsequently approved by the Board of Directors via written resolution on 16 October 2026. This paper is provided for information and to ensure the approved changes are formally recorded in the Board's public business.

2. Key Changes

The Reservation of Powers and Scheme of Delegation has been updated to reflect the Trust's current leadership and management arrangements following the appointment of the Group Chief Executive Officer and the introduction of the Managing Director role.

The revisions:

- Recognise the Group Chief Executive Officer role within the Trust's governance framework and as the Trust's Accounting Officer;
- Introduce the Managing Director role and clarify responsibilities for the day-to-day executive leadership and management of the Trust;
- Clarify the respective accountabilities of the Group Chief Executive Officer and Managing Director;
- Update delegated authorities, approval arrangements and decision-making responsibilities to align with the revised executive structure; and
- Make consequential amendments throughout the document to reflect the revised organisational structure.

The revisions do not materially alter matters reserved to the Board of Directors but ensure that delegated authorities remain aligned with current organisational arrangements

3. Governance Considerations

The amendments support a clear and effective framework of accountability and delegation, ensuring governance arrangements remain aligned with the Trust's organisational structure and leadership responsibilities.

This update represents an initial revision to reflect the Trust's current leadership arrangements. Further work will be undertaken over time to review and, where appropriate, align the Trust's governance documents, including the Reservation of Powers, Standing Orders and Standing Financial Instructions, with partnership

arrangements where this supports consistency while maintaining the Trust's statutory responsibilities and decision-making authority.

4. Recommendation

The Board of Directors is asked to:

- **Note** the amendments made to the Reservation of Powers and Scheme of Delegation.
- **Note** that the revised document was approved by the Board via written resolution on 16 October 2026, following review by the Audit & Risk Committee.

Queen Victoria Hospital
NHS Foundation Trust

Queen Victoria Hospital NHS Foundation Trust

Reservation of Powers and Scheme of Delegation

Effective from 16 October 2026

Approved by the Board of Directors on 16 October 2026

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Introduction

The *Code of governance for NHS provider trusts 2022* requires the board of directors of NHS foundation trusts to have a "schedule of matters specifically reserved for its decisions" (B.2.17) ensuring that management arrangements are in place to enable the clear delegation of its other responsibilities.

The purpose of this document is to provide details of the powers reserved to the Board of Directors, and those delegated to the appropriate level for the detailed application of trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the trust which have not been retained as reserved by the Board of Directors or delegated to a committee or sub-committee of the Board of Directors shall be exercised on behalf of the Board of Directors by the Group Chief Executive Officer. The scheme of delegation identifies those functions, which the Group Chief Executive Officer shall perform personally and those which are delegated to other Directors and Officers. All powers delegated by the Group Chief Executive Officer can be re-assumed by him/her should the need arise.

Where the Trust Board or one of its committees has reached a decision under its terms of reference, the subsequent documentation committing the Trust to that decision will be signed in line with the Standing orders.

It should be emphasised that the financial delegations in themselves give no power to act. The power to act up to the limits prescribed, derives from approved annual plans and budgets and, where applicable, authorised capital and revenue business cases.

Each corporate function is constrained by its agreed annual plan, which governs staffing, facilities and financial resources. Corporate functions may not exceed agreed budgets or deviate from approved plans without prior agreement of the Managing Director.

All projects are bound by these schemes of delegation even where funded partly or wholly from charitable or third party funds. Approval for business cases, and subsequent approval to commit expenditure must be in strict accordance with the detailed scheme of delegation, in addition to the requirement for approval to release funds which are set out in the Trust's charitable fund procedures.

This document covers only matters delegated by the Trust to its senior Officers. Each Director is responsible for delegations within their function and should produce their own scheme of delegation, which should be distributed to all relevant staff, including the finance department.

Director schemes of delegation may not exceed the limits set out in this framework but they may restrict delegation further. All such schemes of delegation should include the requirement that all officers with delegated authority must make formally documented arrangements to cover their delegations in circumstances where they are absent for more than 48 hours.

The Reservation of powers and scheme of delegation should be read in conjunction with the Trust's Standing Orders and Standing Financial Instructions.

Caution over the use of delegated powers
Powers are delegated to Directors and Officers on the understanding they will not exercise delegated powers in a manner which in their judgement is likely to be a cause for public concern.

Directors' ability to delegate their own delegated powers
The Scheme of Delegation shows only the 'top level' of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other established procedures within the Trust. A Director's delegated power may be delegated to designated deputies.

Absence of Directors (or deputy) or Officer to whom powers have been delegated
In the absence of a Director or deputy/Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officer's superior unless alternative arrangements have been identified in the Scheme of Delegation or approved by the Director/Officer's superior.

In circumstances where the Group Chief Executive Officer has not nominated an Officer to act in his/her absence, the Board of Directors shall nominate an Officer to exercise the powers delegated to the Group Chief Executive Officer in his/her absence.

Definition and interpretations
Words importing the singular shall import the plural and vice-versa in each case. In this document:

> **Budget manager** means a member of staff with clear delegated authority from a Director or level 2 manager to manage income and/or expenditure budgets. Delegated authority only applies to a budget manager's specific area of the Trust for which they are responsible for the budget.
>
> **Group Chief Executive Officer** means that, as Accounting Officer, is accountable for the funds entrusted to the Trust. The Group Chief Executive Officer has overall responsibility for the Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met, and has overall responsibility for the Trust's system of internal control. The Group Chief Executive Officer shall also ensure compliance with the NHS foundation trust accounting officer memorandum.
>
> **Managing Director** means the Managing Director of the Trust, responsible for the day-to-day executive leadership and management of the Trust and for the delivery of its operational plans and objectives, within the strategic direction, resources and authorities approved by the Board of Directors. The Managing Director exercises those functions and powers delegated through the Scheme of Delegation or by the Group Chief Executive Officer. The appointment and delegation of functions to the Managing Director does not transfer the Group Chief Executive Officer's responsibilities as Accounting Officer or the Group Chief Executive Officer's overall accountability to the Board of Directors.
>
> **Director** means a formally appointed voting or non-voting director of the Trust Board and unless otherwise specified does not include other personnel who carry the word 'Director' or 'Chief' as part of their title.

Executive leadership team means the formally appointed voting and non-voting executive directors of the Trust Board and the clinical directors meeting as the executive leadership team.

Level 2 manager means staff in the following posts, in relation to their own area of the Trust only:

- General managers
- Heads of Nursing
- Deputies to members of the executive leadership team
- Heads of functions directly reporting to members of the executive leadership team

Unless specified otherwise, all amounts set out in this document exclude Value Added Tax (VAT).

Non-compliance

Failure to comply with the Trust's Reservation of powers and Scheme of delegations may result in disciplinary action in accordance with the relevant disciplinary policy and procedure at that time.

If for any reason the reservation of powers or delegations detailed in this document are not complied with, including the exercise of powers without proper authority, full details of the non-compliance and any justification for non-compliance shall be reported to the next formal meeting of the Audit & Risk committee for determining or ratifying action.

Notwithstanding the above, all members of the Board and all employees must report any instance of non-compliance to the Chief Financial Officer, Group Chief Executive Officer, Managing Director or Company Secretary immediately when they become aware of it.

Roles and responsibilities of the Council of Governors

- Appoint and, if appropriate, remove the Trust Chair
- Appoint and, if appropriate, remove the non-executive directors
- Decide the remuneration and allowances and other terms and conditions of office of the Chair and non-executive directors
- Approve any appointment of a Chief Executive Officer
- Appoint and, if appropriate remove the Trust's external auditor
- Receive the Trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the Council of Governors
- Hold the non-executive directors, individually and collectively, to account for the performance of the Board
- Represent the interests of the members of the Trust as a whole and the interests of the public
- Approve 'significant transactions'
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and service for the health service in England
- Approve amendments to the Trust's constitution

In the event of a dispute between the Council of Governors and Board of Directors:

- In the first instance, the Group Chair, on the advice of the Secretary and other such advice as the Group Chair may see fit to obtain, shall seek to resolve the dispute
- If the Group Chair is unable to resolve the dispute, he/she shall appoint and chair a special committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute
- If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Group Chair may refer the dispute back to the Board of Directors who shall make the final decision

Reservation of Powers to the Board of Directors

The matters below are reserved to the Board for decision making and will not be delegated.

General enabling provision
The Board of Directors may determine any matter it wishes within its statutory powers at a meeting of the Board of Directors convened and held in accordance with the Standing Orders for the Board of Directors. The Board of Directors also has the right to determine that it is appropriate to resume its delegated powers.
Regulation and control
• Approve Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business and other arrangements relating to standards of business conduct. • Approve a Scheme of Delegation of powers from the Board of Directors to Officers which has been prepared by the Group Chief Executive Officer under SO 6.5 (Delegation to Officers) of the SOs. • Delegate executive powers to be exercised by committees or sub-committees, or joint committees of the Board of Directors, and the approval of the terms of reference and specific executive powers of such committees under SO 6.3 (Delegation to committees) of the SOs. • Require and receive the declarations of interest of members of the Board of Directors which may conflict with those of the Trust and determine the extent to which a member of the Board of Directors may remain involved with the matter under discussion. • Approve arrangements for dealing with complaints. • Approve disciplinary procedure for Officers of the Trust. • Adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and agree modifications thereto. For clarity, this will comprise of details of the structure of the Board of Directors and its committees and sub-committees. Organisational structures below Executive Director are the responsibility of the Group Chief Executive Officer who may delegate this function as appropriate. • Ratify any urgent or emergency decisions taken by the Group Chair and Group Chief Executive Officer in accordance with SO 3.4 (Emergency Powers) of the SOs. • Approve arrangements relating to the discharge of the Trust’s responsibilities as a corporate trustee for funds held on trust. • Approve arrangements relating to the discharge of the Trust's Responsibilities as a bailee for patients' property. • Approve proposals of the Nomination and Remuneration Committee regarding Board members and senior Officers and those of the Group Chief Executive Officer not covered by the Nomination and Remuneration Committee. • Discipline Executive Directors who are in breach of statutory requirements or the SOs.

- Subject to the provisions set out in the Standing Orders, the authorisation of the use of the Seal.
- Suspension of the Standing Orders.
- Amendment of the Constitution, in accordance with the Constitution (amendments are subject to approval from the Council of Governors).
- Approval and authorisation of institutions in which cash surpluses may be held.

Committees

- Appoint and dismiss committees of the Trust that are directly responsible to the Board of Directors.
- Establish terms of reference and reporting arrangements for all committees of the Board.
- Appoint and remove members of all committees or sub-committee of the Board of Directors or the appointment of Trust representative to third party organisations.
- Receipt of reports from committees of the Trust including those which the Trust is required by its Constitution, or by the Regulator or by the Secretary of State, or by any other legislation, regulations, directions, or guidance to establish and to take appropriate action thereon.
- Confirm the recommendations of the Trust's committees where the committees do have executive powers.

Strategy, business plans and budgets

- Define the strategic aims and objectives of the Trust.
- Approve the Trust's forward plan and budget in respect of each financial year setting out the application of available financial resources.
- Approve and monitor the Trust’s policies and procedures for the management of risk. Approve key strategic risks.
- Subject to paragraph 54 (Significant Transactions) of the Constitution, ratify proposals for the acquisition, disposal or change of use of land and/or buildings or the creation of any mortgage charge or other security over any asset of the Trust.
- Approve proposals for ensuring quality and developing clinical governance and risk management in services provided by the Trust, having regard to the guidance issued by the Regulator and/or the Secretary of State.
- Approve proposals for ensuring equality and diversity in both employment and the delivery of services.
- Approve the Trust’s investment policy and authorise institutions with which cash surpluses may be held.
- Approve the Trust’s borrowing policy, which will include other long term financing arrangements such as leases.

- Authorise any necessary variations to total budget spend of capital schemes of more than 10% or £50,000, whichever is the greater. Authorise any increase in the total capital programme excluding increases resulting from additional Public Dividend Capital (PDC) allocations to the Trust.

- Approve the Trust's banking arrangements.

- Approve the Trust's Annual Business Plan.

- Consider a merger, acquisition, separation or dissolution of the Trust. An application for a merger, acquisition, separation or dissolution of the Trust may only be made in line with the Trust's Constitution.

- Consider a significant transaction as defined in the Constitution in line with the Constitution.

Monitoring

- Continuously appraise the affairs of the Trust by means of the receipt of reports as it sees fit from members of the Board of Directors, committees, and Officers of the Trust. All monitoring returns required by the Regulator and the Charity Commission shall be reported, at least in summary, to the Board of Directors.

- Consider and approve the Trust's Annual Report and Annual Accounts, prior to submission to the Council of Governors and the Regulator.

- Receive and approve the Annual Report and Accounts for funds held on trust.

- Receive reports from the Chief Finance Officer on financial performance against budget and the annual business plan.

- All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board.

Audit arrangements

- Receive reports of Audit and Risk Committee meetings and take appropriate action.

- Receive the annual management letter from the external auditor and agree action on the recommendations where appropriate of the Audit and Risk Committee.

- Receipt of a recommendation of the Audit and Risk Committee in respect of the appointment of Internal Auditors (note: the recommendation in respect of External Auditors is made by the Audit and Risk Committee to the Council of Governors).

Committee Delegation

The Board of Directors may determine that certain powers shall be exercised by committees of the Board of Directors and these shall be set out within the committee terms of reference. The composition and terms of reference of such committees shall be determined by the Board of Directors taking into account the reservation of powers as agreed by the Board and where necessary the requirements of the Regulator and/or the Charity Commission (including the need to appoint an Audit and Risk Committee and a Remuneration Committee). The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with the Standing Orders, committees of the Board of Directors may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors. The Board of Directors have delegated decisions/duties to the following committees:

- Audit and Risk Committee
- Nomination and Remuneration Committee
- Charity Committee
- Quality and Safety Committee
- Finance and Performance Committee
- People Committee
- Strategy and Culture Committee

A list of committees, along with their terms of reference, shall be maintained by the Company Secretary and are available on the Trust's website: https://www.qvh.nhs.uk/about-us/board-of-directors/

Board Member Responsibilities

Group Chief Executive Officer
Accounting Officer to Parliament for stewardship of Trust resources including ensuring the propriety and regularity of the public finances for which they are responsible, the keeping of proper accounts, prudent and economical administration in line with the principles set out in the governments 'managing public money' publication, the avoidance of waste and extravagance and the efficient and effective use of all the resources in their charge Sign the accounts on behalf of the Board of Directors. Ensure effective internal controls that safeguard public funds and assist the Group Chair to implement requirements of corporate governance including ensuring managers: • Have a clear view of their objectives and the means to assess achievements in relation to those objectives • Be assigned well defined responsibilities for making best use of resources • Have the information, training and access to the expert advice they need to exercise their responsibilities effectively.
Managing Director
Responsible for the day-to-day executive leadership and management of the Trust and for the delivery of its operational plans and objectives within the strategic direction, resources and delegations approved by the Board of Directors. **Ensure effective management arrangements are in place for performance, resources and risk, and exercise those powers and responsibilities specifically delegated to the Managing Director through the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.** **Accountable to the Group Chief Executive Officer and the Board of Directors for the exercise of those delegated responsibilities.**
Group Chief Executive Officer and Chief Finance Officer
Ensure the accounts of the Trust are prepared under principles and in a format directed by the regulator. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs.
Group Chair
Leadership of the Board of Directors, ensuring its effectiveness on all aspects of its role and setting its agenda for meetings of the Board of Directors. Ensuring the provision of accurate, timely and clear information to the Directors and the Council of Governors. Ensuring effective communication with Officers, patients and the public. Arranging the regular evaluation of the performance of the Board of Directors, its Committees and individual Directors.

Facilitating the effective contribution of Non-Executive Directors and ensuring constructive relations between Executive and Non-Executive Directors.

Board of Directors

Meet regularly and to retain full and effective control over the Trust

Collective responsibility for adding value to the Trust, for promoting the success of the Trust by directing and supervising the Trust's affairs

Provide active leadership of the Trust within a framework of prudent and effective controls which enable risk to be assessed and managed

Set the Trust's strategic aims, ensure that the necessary financial and human resources are in place for the Trust to meet its objectives, and review management performance

Set the Trust's values and standards and ensure that its obligations to patients, the local community and the Regulator are understood and met.

All members of the Board of Directors

Share corporate responsibility for all decisions of the voting members of the Board of Directors.

Non-executive Directors

To bring independent judgement to bear on issues of strategy, performance, key appointments and accountability by:

- Constructively challenge and contribute to the development of strategy
- Scrutinise the performance of management in meeting agreed goals and objectives and monitor the reporting of performance
- Satisfy themselves that financial information is accurate and that financial controls and systems of risk management are robust and defensible
- Determine appropriate levels of remuneration of executive directors and have prime role in appointing and where necessary, removing senior management and in succession planning
- Ensure the board acts in the best interests of the public and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

Sitting on Committees of the Board of Directors.

Financial Limit Delegations

Approval of business case and service developments
Applies to all business cases and service developments. Does not include setting of pay and non-pay budgets as part of annual planning process.

A business case is a document that provides the rationale for why the Trust should agree to fund a particular project.

This delegation has application when a business case requesting funding is required to be prepared and approved. Note: delegations relating to procurement or the signing of a contract are outlined separately *(see section on signature of legally binding contracts)*.

A business case is required in the following situations:

- When funding is requested in excess of allocated budget OR
- A significant change to the model of service delivery or model of care is proposed OR
- An increase to the workforce establishment is proposed.

The Business Case Review Group is required to scrutinise all business cases requesting new budget from the contingency prior to the case going to the Trust's Executive Leadership Team and the Capital Investment Group (where relevant) for endorsement, and then the Finance and performance committee of the Trust Board or Trust Board (dependent on the financial value) for final approval.

Determining the appropriate approval process
The appropriate approval process for a business case is determined by the value of the business case. The following principles should be applied to calculate the value of the business case:

- For non-pay or capital expenditure business cases, the value of the business case should be calculated on the basis of the total cost over 5 years
- For pay expenditure business cases, the value of the business case should be calculated based on the annual cost, and
- For business cases combining non-pay, capital and pay expenditure, the value of the business case should be calculated on the basis of the total cost over 5 years.
- New revenue budgets can only be funded from the Trust reserves or within existing revenue budgets; additional capital budgets can only be funded from within the approved capital plan or from an additional allocation of PDC to the Trust

Escalating the business case approval process
There will be situations where a business case is relatively low value but of strategic importance to the Trust. Accordingly, any Executive Director has the right to override these delegations to escalate approval up the approval process. Example situations include:

- Politically or commercially sensitive, novel or contentious
- Outsourcing of a service with implications on staffing
- Deemed of strategic importance and intrinsically linked to the Trust's strategic direction and priorities, or
- Where the Directorate is not meeting its budget control total.

An Executive Director cannot override these delegations to de-escalate approval down the approval process.

Revenue expenditure (5 year value)	
Up to £250,000	Chief Finance Officer
£250,001 to £500,000	Chief Finance Officer AND Managing Director
£500,001 to £1,000,000	Executive Leadership Team
£1,000,001 to £2,000,000	Finance & Performance committee
Over £2,000,001	Board of Directors
Capital expenditure and disposals	
Up to £250,000	Chief Finance Officer
£250,001 to £500,000	Chief Finance Officer AND Managing Director
£500,001 to £1,000,000	Executive Leadership Team
£1.000,001 to £2,000,000	Finance & Performance committee
Over £2,000,001	Board of Directors
Virements (reallocation of budgets)	
Within a Business Unit/Directorate	Level 2 Managers responsible for cost centres
Between Business Units/Directorates	Directors responsible for the relevant cost centres
Trust wide virements (e.g. Pay award adjustments)	Chief Finance Officer AND Managing Director

Quotations, tenders and selection of suppliers
Also refer to the Procurement Department for further guidance: in many cases goods and services will already have been subject to a competitive exercise and there may be no requirement for further quotations or competition.

All thresholds apply to the aggregate value of orders, which may be across different areas of the Trust. All staff must consult the Procurement Department for guidance if they are unsure, who are jointly responsible with the approver for ensuring that thresholds are not breached trust-wide.

UK procurement financial thresholds are limits set that define which specific procurement rules apply during a procurement episode. As these thresholds regularly change and the Public Procurement Regulations are periodically updated, all staff must consult the Procurement department for guidance.

Where a public contract is awarded above £10,000 (including framework call-offs) it must be published as an awarded opportunity notice on Contracts Finder to comply with transparency requirements.

Capital/revenue expenditure	**Minimum requirements**
Up to £20,000	1 Written quote (Authorised by Budget Manager)

£20,001 to £75,000	3 Written quotes (Authorised by Budget Manager)
£75,001 to UK procurement financial Threshold (contact procurement department for current value)	Competitive Tender Exercise (Level 2 Manager AND Chief Finance Officer)
Over UK procurement financial threshold (see note above – threshold is different for works and non-works)	UK procurement financial threshold (Relevant Director AND Chief Finance Officer)
Quotation and tenders process waivers	
Waiving of tender and quotation for items where estimates expenditure is less than £30,000 but greater than £20,000 (less than £20,000 requires only 1 quote)	Deputy Chief Finance Officer
Waiving of tender and quotation for items where estimated expenditure is less than £250,000 but greater than £30,000	Chief Finance Officer, or Managing Director (when Chief Finance Officer has commissioned the item or where there is a conflict)
Waiving of tender and quotation for items where estimated expenditure is less than £1,000,000 but greater than £250,000.	Managing DirectorAND Chief Finance Officer
Waiving of tender and quotation for items where estimated expenditure is greater than £1,000,000	Board of Directors
Opening tenders	
Electronic tenders received through on line e-Tendering tool.	Head of Procurement or Deputy Chief Finance Officer / Chief Finance Officer (in absence of Head of Procurement)
Committing expenditure	
Revenue and non-capital works expenditure and invoice requests within approved financial plans or business plans	
Up to £20,000	Budget Holder
Up to £50,000	Level 2 Manager
Up to £100,000	Director
Up to £250,000	Chief Finance Officer OR Chief Operating Officer
Up to £500,000	Chief Finance Officer AND Chief Operating Officer
Over £500,000	Chief Finance Officer AND Managing Director
Approval of Capital invoices Where a significant contract is approved by the Trust Board, the Chief Finance Officer will have the delegation to raise and approve any purchase orders required related to the approved contract. Evidence of Board approval must be provided with the requisition.	

Up to £20,000	Capital Scheme Budget Manager
Up to £50,000	Level 2 Manager
Up to £100,000	Director
Up to £250,000	Chief Finance Officer OR Chief Operating Officer
Up to £1,000,000	Chief Finance Officer AND Chief Operating Officer
Over £1,000,001	Chief Finance Officer AND Managing Director
Granting and termination of equipment leases and credit finance	
Trust's employee lease car scheme	Chief Finance Officer
Leases/arrangements up to £250,000	Chief Finance Officer
Leases/ arrangements £250,001 to £1,000,000	Chief Finance Officer AND Managing Director
Leases / arrangements £1,000,001-£2,000,000	Finance & Performance committee
Leases / arrangements over £2,000,001	Board of Directors
Agreements and licences Letting or licencing of premises to or from other organisations (see also section below on signature of legally binding contracts for guidance on who can sign these agreements)	
Up to £250,000	Chief Finance Officer
£250,000 to £1,000,000 and signing of Landlord and Tenant Act notices relating to the acquisition or granting of leases	Chief Finance Officer AND Group Chief Executive Officer
£1,000,001 to £2,000,000	Finance & Performance committee
Over £2,000,001	Board of Directors
Condemning and disposal Items obsolete, obsolescent, redundant, irreparable or unable to be repaired cost effectively	
Up to £5,000 (carrying value)	Director or Deputy Chief Finance Officer
Over £5,000 (carrying value)	Chief Finance Officer (may be delegated in specific cases in writing, but no lower than to a level 2 manager)
Transfer or sale of assets to another organisation	Chief Finance Officer

Losses, write-offs and compensation Note: 'novel, contentious or repercussive cases' should be deferred to the Department of Health for approval	
Losses of cash, damage or loss of buildings, fittings, furniture, equipment or property in stores, compensation payments made under legal obligation (excluding clinical negligence), write off of debtors (including salary overpayments)	
Up to £10,000	Deputy Chief Finance Officer
Up to £50,000	Chief Finance Officer
Over £50,001	Audit & Risk committee
Fruitless Payments (including abandoned capital schemes)	
Up to £10,000	Deputy Chief Finance Officer
Up to £50,000	Chief Finance Officer
Over £50,001	Audit & Risk committee
Ex-Gratia payments to patients and Officers for loss of personal effects. Police report required for losses over £100.	
Up to £10,000	Deputy Chief Finance Officer
Up to £50,000	Chief Finance Officer
Over £50,001	Approval noted by Audit & Risk committee
Ex-Gratia payments for clinical negligence or personal injury claims involving negligence or any other ex-gratia payments (where legal advice obtained and followed)	
Up to £50,000	Chief Finance Officer
£50,001 to £100,000	Managing Director AND Chief Finance Officer
Over £100,000	Audit & Risk Committee
Reimbursement of patients monies	
Chief Finance Officer or Chief Operating Officer	
Removal expenses, excess rent and house purchase expenses	
Chief People Officer	
Contractual and non-contractual severance payments and all non-contractual payments, excluding Directors.	
Up to £20,000	Chief People Officer
Over £20,000	Chief Finance Officer AND Managing Director
Expenditure from charitable funds	
Up to £2,000	Director or Trust Charity Lead

Up to £30,000	QVH Charity Committee
Over £30,000	Corporate Trustee
Signature of legally binding documents All individuals signing contracts have a responsibility to review and assure themselves that they provide value for money and that due care has been exercised in their preparation, with formal legal advice provided if necessary. This applies to contracts that appear to have no financial value, as these might have financial or non-financial implications from termination.	
Signature to approve invoices or otherwise commit expenditure (e.g. engagement letter), without any further legally binding obligations.	See 'Committing Expenditure' above
Signature of any document that will be a necessary step in legal proceedings involving the Trust (excluding valuation tribunal appeals and similar day-to-day property-related matters).	To be signed in line with the Trust's Standing Orders
Signature of the following property documents when part of day to day business and within approved business plans and financial envelopes: • Notices to activate rent reviews and lease expiries • Notices requiring signature on the granting of leases and licences • Licences permitting alterations or minor works by us in third party property or by others in our properties.	Associate Director of Estates and facilities
Signature of other contracts or other legally binding documents not required to be executed as a deed (see Standing Orders for guidance on documents to be executed as a deed), the subject matter and nature of which has been approved by the Board or committee to which the Board has delegated appropriate authority:	
Up to £100,000	Director
Up to £250,000	Chief Finance Officer
Over £250,001	Chief Finance Officer AND Managing Director
Setting of fees, charges and income	
Private patient, overseas visitors, income generation and other patient related services	Associate Director Business Development

Price of NHS contracts	
Setting fees and charges for contracts up to £50,000 per annum	Director
Setting fees and charges for contracts over £50,000 per annum	Chief Finance Officer
Authorisation of income credit notes	
Up to £20,000	Budget holders
Up to £50,000	Level 2 managers, Financial Services Manager and Associate Director Business Development
Up to £100,000	Director
Up to £250,000	Chief Finance Officer
Up to £1,000,000	Chief Finance Officer AND Managing Director
Over £1,000,000	Board of Directors
Department of Health Interim Revenue Support Where the Trust is trading at a deficit and there is a cash support requirement from the Department of Health and Social Care (DHSC) to maintain operations. The total cash support requirement will be approved by the Board as part of the annual planning process. The cash support will be provided via an interim revenue support loan from the DHSC. The approval of the loan for the drawdown of the cash will be authorised per the limits below. Details of all loan agreements are reported to and overseen by the Finance and Performance Committee with prior approval by the Board through the agreement of the Operating Plan submission.	
£0 - £1,000,000	Chief Finance Officer
£1000,001 - £2,000,000	Chief Finance Officer AND Group Chief Executive Officer
Above £2,000,000	Board of Directors
Approval to align with NHSE guidance if that differs from the above approval limits.	

Scheme of Delegation of Powers from Standing Orders

Duties delegated	SO ref
Group Chair	
Final authority on the interpretation of the SOs.	1.2
Responsible for the operation of the Board of Directors.	3.11
Chair all meetings of the Board of Directors and associated responsibilities.	3.11
Call meetings of the Board of Directors.	4.2
Sign notices of meetings of the Board of Directors.	4.4
Give final ruling to permit late requests for items to be included on the agenda for meetings of the Board of Directors.	4.11
Chair all meetings of the Board of Directors.	4.25
Give final ruling in questions of order, relevancy and regularity of meetings.	4.28
Have a second or casting vote.	4.33
Sign minutes of the proceedings of meetings of the Board of Directors.	4.45
Issue directions regarding arrangements for meetings of the Board of Directors and accommodation of the public and press.	4.48
Group Chief Executive Officer	
Responsible for the overall performance of the executive functions of the Trust. Responsible for ensuring the discharge of obligations under applicable financial directions, the Regulator guidance and in line with the requirements of the NHS foundation trust accounting officer memorandum.	3.6
The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board of Directors	6.6
Ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within the SOs and SFIs.	12.1
Managing Director	
Exercise those functions and powers delegated to the Managing Director through the approved Scheme of Delegation or otherwise by the Chief Executive, within the limits of that delegation. Accountability for functions delegated by the Chief Executive remains with the Chief Executive.	6.4
Group Chair, Group Chief Executive Officer and Managing Director	
The powers which the Board of Directors has reserved to itself with the SOs may in emergency or for an urgent decision be exercised by the Group Chief Executive Officer/ Managing Director and the Group Chair after having consulted at least two Non-Executive	6.2

Duties delegated	SO ref
Directors. The exercise of such powers by the Group Chief Executive Officer and Group Chair shall be reported to the next formal meeting of the Board of Directors in public session for formal ratification.	
Chief Finance Officer	
Responsible for the provision of financial advice to the Trust and to members of the Board of Directors and for the supervision of financial control and accounting systems.	3.7
Chief Finance Officer and Managing Director	
Approve and sign any building, engineering, property or capital document.	10.3
Secretary	
Advise the Group Chair on the interpretation of the SOs.	1.2
Include any petition received by the Trust on the agenda for the next meeting of the Board of Directors.	4.13
Prepare minutes of the proceedings of the meetings of the Board of Directors and submit minutes for agreement at the next meeting of the Board of Directors.	4.45
A register of interests shall be established and maintained.	7.6
Keep the Trust's Seal in a secure place.	10.1
Secretary / Group Chair	
Where a Director has any doubt about the relevance of an interest, this should be discussed with them.	7.4
Directors	
Duty not to solicit for any person any appointment under the Trust or recommend any person for such appointment, and disclose informal discussions outside appointment panels or committees to the panel or committee.	7.20
On appointment, disclose to the Board of Directors whether you are related to any other Director or holder of any officer under the Trust.	7.24
Executive Directors	
Prior to acceptance of any appointment, disclose to the Group Chief Executive Officer/ Managing Director whether you are related to any other Director or holder of any officer under the Trust.	7.23
Group Chief Executive Officer / Managing Director / nominated Executive Director	
Approve and sign all documents which will be necessary in legal proceedings.	11.1
Group Chief Executive Officer / Managing Director / nominated officer	
Authority to sign any agreement or document (save for deeds) the subject matter of which has been approved by the Board of Directors or a committee thereof.	11.2

Scheme of Delegation of Powers from Standing Financial Instructions

Responsibilities and delegation	SFI ref
Group Chair	
Final authority on interpretation of the SFIs.	1.2.1
Group Chief Executive Officer	
The Group Chief Executive Officer is the trust's accounting officer.	2.4.1
To ensure all existing officers and new appointees are notified of their responsibilities within the SFIs.	2.4.4
To ensure that financial performance measures with reasonable targets have been defined and are monitored, with robust systems and reporting lines in place to ensure overall performance is managed and arrangements are in place to respond to adverse performance.	2.4.6
Determine whether powers devolved under the SFIs and the scheme of delegation be taken back to a more senior level.	2.4.7
To ensure that the trust provides an annual forward plan to the regulator each year.	2.4.8
Group Chief Executive Officer & Group Chair	
To ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.	2.4.5
Chief Finance Officer	
Responsible for: • Advising on and implementing the trust's financial policies; • Design, implementation and supervision of systems of internal financial control; • Ensuring that sufficient records are maintained to show and explain the trust's transactions, in order to report; • Provision of financial advice to other directors of the board and employees; and • Preparation and maintenance of records the trust may require for the purpose of carrying out its statutory duties	2.5.1
Group Chief Executive Officer / Chief Finance Officer	
Advise the Group Chair on the interpretation of the SFIs.	1.2.1
Audit	**SFI ref**
Audit and Risk committee	
Provide an independent and objective view of internal control by: • Overseeing internal and external audit services (including agreeing both audit plans and monitoring progress against them);receiving reports from the internal and external auditors (including the external auditor's management letter) and considering the management response; • Monitoring compliance with SOs and SFIs;	3.2.1

• Reviewing schedules of losses and compensations and making recommendations to the board of directors; • Reviewing the information prepared to support the annual governance declaration statement.	
To ensure that external audit is providing a cost effective service that meets the prevailing requirements of the regulator and other regulatory bodies.	3.5.1
Chair of the Audit and Risk committee	
Where audit and risk committee considers there is evidence of ultra vires transactions or improper acts or important matters that the audit and risk committee wishes to raise, the matter shall be raised at a full meeting of the board of directors.	3.2.3
Chief Finance Officer	
In relation to audit, the Chief Finance Officer is responsible for: • Ensuring there are arrangements to review, evaluate and report on effectiveness of internal financial control by establishment of internal audit function; • Ensuring the internal audit is adequate and meets the NHS mandatory audit standards; • Ensuring the production of annual governance statement for inclusion in trust's annual report; • Provision of annual reports; • Ensuring effective liaison with relevant counter fraud services regional team or NHS protect; and • Deciding at what stage to involve police in cases of misappropriation or other irregularities.	3.3.1
Responsible for the promotion of counter fraud measure within the trust and ensure that the trust co-operate with NHS protect in relation to the prevention, detection and investigation of fraud in the NHS.	3.6.2
Ensure the trust's local counter fraud specialist receives appropriate training in connection with counter fraud measures.	3.6.4
Be satisfied that the terms on which the services of a local counter fraud specialist from an outside organisation are provided are such to enable the local counter fraud specialist to carry out his functions effectively and efficiently.	3.6.5
Prepare a 'fraud response plan' that sets out the action to be taken in connection with suspected fraud.	3.6.11
Inform police if theft or arson is involved.	3.6.12
For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness (except if trivial and where fraud is not suspected), immediately notify the board of directors and the auditor.	3.6.13
To establish procedures for the management of expense claims submitted by officers.	3.7.1
Chief Finance Officer / designated auditors	
Entitled to require and receiver without prior notice:	3.3.2

• Access to all records, documents, correspondence relating to any financial or other relevant transactions; • Access at all reasonable times to any land, premises or members of the board of directors or officers of the trust; • Production of any cash, stores or other property of the trust under the control of a member of the board of directors or officers; and • Explanations concerning any matter under investigation.	
Internal audit	
To review, appraise and report on compliance with policies, plans and procedures; adequacy of control, suitability of financial and management data and the extent to which the trust's assets and interests are accounted for.	3.4.2
To assess the process in place to ensure the assurance frameworks are in accordance with current guidance from the regulator.	3.4.3
To notify the Chief Finance Officer should any matter arise which involves, or is thought to involve, irregularities concerning cash, stores or other property.	3.4.4
Lead internal auditor	
Attend meetings of the audit and risk committee and have right of access to all members of the audit and risk committee, the Group Chair and the Managing Director of the trust.	3.4.5
Managing Director and Chief Finance Officer	
Monitor and ensure compliance with guidance issued by the regulator or NHS protect on fraud and corruption in the NHS.	3.6.1
Chief Finance Officer and local counter fraud specialist	
At the beginning of each financial year, prepare a written work plan outlining the local counter fraud specialist's projected work for that financial year.	3.6.7
Secretary	
Ensure that all officers are made aware of the trust's standards of business conduct and additional rules in respect of preventing corruption and complying with the bribery act 2010.	3.8.1
To record in writing, notification of any gift, hospitality or sponsorship accepted (or refused) by officers on behalf of the trust.	3.8.2
Council of Governors	
Appoint external auditor to the trust.	3.5.1
Annual planning, budgets, budgetary control and monitoring	**SFI ref**
Group Chief Executive Officer	
Compile and submit to the board of directors and the regulator, strategic and operational plans.	4.1.1
Chief Finance Officer	
Prepare and submit the operational plan to the financial and performance committee, the Board of Directors and the regulator	4.1.2

Compile and submit financial estimates and forecasts for both revenue and capital to the Board of Directors	4.1.3
Ensure adequate training is delivered on an ongoing basis to enable the Group Chief Executive Officer, Managing Directorand other Officers to carry out their budgetary responsibilities.	4.2.4
Finance and performance committee	
Submit budgets to the board of directors for approval.	4.2.1
All directors	
To meet their financial targets as agreed in the annual plan approved by the board of directors.	4.2.4
Annual accounts and reports	**SFI ref**
Group Chief Executive Officer	
Certify annual accounts.	5.2
Chief Finance Officer	
Prepare financial returns in accordance with the guidance given by the regulator and the secretary of state for health, the treasury, the trust's accounting policies and generally accepted accounting principles.	5.1
Prepare annual account. Submit annual accounts and any report of auditor on them to the regulator.	5.2
Bank accounts	**SFI ref**
Chief Finance Officer	
Manage the trust's banking arrangements including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.	6.1–6.6
Financial systems and transaction processing	**SFI ref**
Chief Finance Officer	
Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.	7.1-7.8
Approve arrangements for making disbursements from cash received.	7.12
Contracts for provision of services to customers	**SFI ref**
Chief Finance Officer	
Negotiating contracts with commissioners for the provision of services to patients in accordance with the annual plan.	8.1
Setting the framework and overseeing the process by which provider to provider contracts, or other contracts for the provision of services by the trust, are designed and agreed.	8.4

Contracts, tenders and healthcare service agreements	SFI ref
Group Chief Executive Officer / Managing Director	
Ensure that best value for money can be demonstrated for all services provided under contract or in-house.	9.1.2
Nominate officers to commission service agreements with providers of healthcare.	9.12.2
Nominate an officer who shall oversee and manage each contract on behalf of the trust.	9.13.3
Ensure that best value for money can be demonstrated for all services provided on an in-house basis.	9.1.2
Chief Finance Officer	
Advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained, establish procedures to ensure that competitive quotations and tenders are invited for the supply of goods and services and ensure that a register is maintained of all formal tenders.	9.1.3
Establish procedures to carry out financial appraisals and shall instruct the appropriate requisitioning officer to provide evidence of technical competence.	9.4.1
Enquiries concerning the financial standing and financial suitability of approved contractors.	9.7.1
Group Chief Executive Officer/ Managing Director/ Chief Finance Officer	
Approval of awarding of contracts for which tendering is deemed not strictly competitive.	9.5.15
Where one tender is received will assess for value for money and fair price.	9.6.16
Terms of service, officer appointments and payments	**SFI ref**
Group Chief Executive Officer	
Present to the board of directors procedures for determination of commencing pay rates, conditions of service etc. for Officers.	10.2.3
Chief Finance Officer	
Make arrangement for the provision of payroll services to the trust to ensure the accurate determination for any entitlement and to enable prompt and accurate payment to officers.	10.4.1
Issue detailed procedures covering payments to officers.	10.4.3
Chief Finance Officer and Chief People Officer	
Approve advances of pay.	10.5.1
Non-pay expenditure	**SFI ref**
Managing Director	
Determine the level of delegation to budget managers.	11.1.1

Set out the list of managers who are authorised to place requisitions for the supply of goods and services, and, the financial limits for requisitions and the system for authorisation above that level.	11.1.2
Set out procedures on the seeking of professional advice regarding the supply of goods and services.	11.1.4
Chief Finance Officer	
Responsible for the prompt payment of accounts and claims.	11.2.3
• Advise the board of directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. • Prepare detailed procedures for requisitioning, ordering, receipt and payment of goods, works and services. • Be responsible for the prompt payment of all properly authorised accounts and claims. • Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. • Ensure a system for submission to the Chief Finance Officer of accounts for payment. • Maintain a list of officers, including specimens of their signatures, authorised to certify any type of payment. • Delegate responsibility for ensuring that payment for goods and services is only made once goods/services are received. • Prepare and issue procedures regarding vat.	11.3.1
Approve proposed prepayment arrangements	11.5.1
Group Chief Executive Officer / Managing Director / Chief Finance Officer	
Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within health building note 00-08.	11.6.6
Budget managers	
To appoint nominees who must be approved by the Chief Finance Officer, and to remain responsible for the actions of nominees when they act in place of the budget manager.	11.1.3
Equity investments, external borrowing, public dividend capital and mergers and acquisitions	**SFI ref**
Chief Finance Officer	
Produce an investment policy in accordance with any guidance received from the regulator.	12.1.1
Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.	12.1.3
Advise the board of directors concerning the trust's ability to pay interest on, and repay the public dividend capital (PDC) and any proposed commercial borrowing.	12.2.1
Applications for a loan or overdraft.	12.2.2
Prepare detailed procedural instructions concerning applications for loans and overdrafts.	12.2.3

Approval of short terms borrowing requirements.	12.2.4
Capital investment and assets	**SFI ref**
Group Chief Executive Officer / Managing Director	
• Ensure adequate appraisal and approval processes are in place for determining capital expenditure priorities. • Management of all stages of capital schemes and for ensuring that schemes are delivered on time and to planned cost. • Ensure investment is not undertaken without confirmation, where appropriate, of responsible director's support and the availability of resources to finance all revenue consequences.	13.1.1-13.1.3
Chief Finance Officer	
Prepare detailed procedural guides for the financial management and control of expenditure on capital assets, including the maintenance of an asset register.	13.2.1
Implement procedures to comply with guidance on valuation contained within the treasury's guidance.	13.2.2
Establish procedures covering the identification and recording of capital additions.	13.2.3
Develop procedures covering the physical verification of assets on a periodic basis.	13.2.4
Develop policies and procedures for the management and documentation of asset disposals.	13.2.5
Stores and receipts of goods	**SFI ref**
Group Chief Executive Officer / Managing Director	
Delegate overall responsibility for the control of stores.	14.1.1
Identify those officers authorised to requisition and accept goods from the NHS supply chain.	14.2.1
Chief Finance Officer	
Responsible for systems of control.	14.1.1
Set out procedures and systems to regulate the stores including records for receipt of goods, issues and returned to stores and losses.	14.1.5
Agreed stocktaking arrangements.	14.1.6
Approval of alternative arrangements where a complete system of stores control is not justified.	14.1.7
Pharmaceutical officer	
Responsible for the control of any pharmaceutical stocks.	14.1.3
Disposals and condemnations, losses and special payments	**SFI ref**
Chief Finance Officer	

Prepare detailed procedures for the disposal of assets including condemnations, and ensure members of the board of directors and relevant officers are notified of this.	15.1.1
Approve form to in which to record the condemning of unserviceable assets and provide a list of officers to countersign entries.	15.2.1
Prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments.	15.3.1
Immediately inform the police if theft or arson is involved in a suspected criminal offence.	15.3.3
Inform the trust's local counter fraud specialist (LCFS) and NHS Protect in cases of fraud or corruption.	15.3.4
Notify the audit and risk committee, LCFS and the external auditors of all frauds.	15.3.5
Notify the board of directors, external auditor and the audit and risk committee, at the earliest opportunity of losses apparently caused by theft, arson, or neglect of duty, except if trivial, or gross carelessness.	15.3.6
Take steps to safeguard the trust's interest in bankruptcies and company liquidations. Consider whether any insurance claim can be made for any losses incurred by the trust.	15.3.8
Maintain a losses and special payments register in which write-off action is recorded and regularly report losses and special payments to the audit and risk committee on a regular basis.	15.3.9
Head of department	
Advise the Chief Finance Officer of the estimated market value of the item to be disposed of.	15.1.2
Condemning officers	
Report evidence of negligence in use of assets to the Chief Finance Officer.	15.2.3
Managers	
Report discovered or suspected losses of any kind to the Group Chief Executive Officer, Managing Director and Chief Finance Officer	15.3.2
Information technology	**SFI ref**
Chief Finance Officer	
Responsible for the accuracy and security of the computerised financial data of the trust and shall: • Devise and implement any necessary procedures to ensure adequate and reasonable protection of the trust's data, programmes and computer hardware; • Ensure that adequate and reasonable controls exist over data entry, processing, storage, transmission and output; • Ensure that adequate controls exist such that computer operation is separated from development, maintenance and amendment; • Ensure that an adequate audit trail exists through the computerised system; • Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation; and	16.1

• Publish and maintain a freedom of information (FOI) publication scheme.	
Ensure that contracts for computer services for financial applications clearly define the responsibility of all parties and ensure rights of access for audit purposes.	16.2.1
Periodically seek assurances that adequate controls are in operation.	16.2.2
Ensure that risks to the trust arising from the use of information technology are effectively identified, considered and appropriate action taken to mitigate or control risk.	16.3.1
• Ensure that systems acquisition, development and maintenance are in line with corporate policies such as the trust's information technology strategy. • Ensure that data produced is complete and timely and accessible to the trust's finance officers. • Ensure computer audit reviews are carried out as necessary.	16.4.1
Patients' property	**SFI ref**
Managing Director	
Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.	17.3
Chief Finance Officer	
Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all officers whose duty is to administer, in any way, the property of patients.	17.4
Senior officers	
Inform officers, on appointment, their responsibilities and duties for the administration of the property of patients.	17.5
Retention of records	**SFI ref**
Group Chief Executive Officer / Managing Director	
Maintain archives for all documents required to be retained in accordance with the regulator and/or secretary of state guidelines.	18.1
Produce a records lifecycle policy, detailing the secure storage, retention periods and destruction of records to be retained.	18.2
Risk management and insurance	**SFI ref**
Group Chief Executive Officer / Managing Director	
Ensure that the trust has a programme of risk management which shall be approved and monitored by the board of directors.	19.1
Responsible for ensuring that the existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal financial control within the annual report and annual accounts.	19.3
Chief Finance Officer	

Ensure that insurance arrangements exist in accordance with the trust's risk management policy.	19.4
Funds held on trust (charitable funds)	**SFI ref**
Chief Finance Officer	
Ensure that funds held on trust (charitable funds) are administered in line with statutory provisions, the trust's governance documents and charity commission guidance. Prepare procedural guidance in relation to the management and administration, disposition, investment, banking, reporting, accounting and audit of the funds held on trust (charitable funds) for the discharge of the board of directors responsibilities as the corporate trustee.	20.5